DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 405, 410, 411, 413, 414, 424, and 426

[CMS–1502–FC and CMS–1325–F]

RINs 0938–AN84 and 0938–AN58

Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2006 and Certain Provisions Related to the Competitive Acquisition Program of Outpatient Drugs and Biologicals Under Part B

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule with comment.

SUMMARY: This rule addresses Medicare Part B payment policy, including the physician fee schedule that are applicable for calendar year (CY) 2006; and finalizes certain provisions of the interim final rule to implement the Competitive Acquisition Program (CAP) for Part B Drugs. It also revises Medicare Part B payment and related policies regarding: Physician work; practice expense (PE) and malpractice relative value units (RVUs); Medicare telehealth services; multiple diagnostic imaging procedures; covered outpatient drugs and biologicals; supplemental payments to Federally Qualified Health Centers (FQHCs); renal dialysis services; coverage for glaucoma screening services; National Coverage Decision (NCD) timeframes; and physician referrals for nuclear medicine services and supplies to health care entities with which they have financial relationships. In addition, the rule finalizes the interim RVUs for CY 2005 and issues interim RVUs for new and revised procedure codes for CY 2006. This rule also updates the codes subject to the physician self-referral prohibition and discusses payment policies relating to teaching anesthesia services, therapy caps, private contracts and opt-out, and chiropractic and oncology demonstrations.

As required by the statute, it also announces that the physician fee schedule update for CY 2006 is −4.4 percent, the initial estimate for the sustainable growth rate for CY 2006 is 1.7 percent and the conversion factor for CY 2006 is $36.1770.

DATES: *Effective Date:* These regulations are effective on January 1, 2006.

Comment Date: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on January 3, 2006.

ADDRESSES: In commenting, please refer to file code CMS–1502–FC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (no duplicates, please):

1. *Electronically.* You may submit electronic comments on specific issues in this regulation to *http://www.cms.hhs.gov/regulations/ecomments.* (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. *By regular mail.* You may mail written comments (one original and two copies) to the following address ONLY:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1502–FC, P.O. Box 8017, Baltimore, MD 21244–8017.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments (one original and two copies) to the following address ONLY:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1502–FC, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–7197 in advance to schedule your arrival with one of our staff members. Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or 7500 Security Boulevard, Baltimore, MD 21244–1850.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

Submission of comments on paperwork requirements. You may submit comments on this document's paperwork requirements by mailing your comments to the addresses provided at the end of the ''Collection of Information Requirements'' section in this document.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Pam West (410) 786–2302 (for issues related to practice expense).

Rick Ensor (410) 786–5617 (for issues related to the nonphysician workpool and supplemental survey data).

Stephanie Monroe (410) 786–6864 (for issues related to the geographic practice cost index and malpractice RVUs).

Craig Dobyski (410) 786–4584 (for issues related to list of telehealth services).

Ken Marsalek (410) 786–4502 (for issues related to multiple procedure reduction for diagnostic imaging services and payment for teaching anesthesiologists).

Henry Richter (410) 786–4562 (for issues related to payments for end stage renal disease facilities).

Angela Mason (410) 786–7452 or Catherine Jansto (410) 786–7762 (for issues related to payment for covered outpatient drugs and biologicals).

Fred Grabau (410) 786–0206 (for issues related to private contracts and opt out provision).

David Worgo (410) 786–5919 (for issues related to Federally Qualified Health Centers).

Dorothy Shannon (410) 786–3396 (for issues related to the outpatient therapy cap).

Vadim Lubarsky (410) 786–0840 (for issues related to National Coverage Decision timeframes).

Bill Larson (410) 786–7176 (for issues related to coverage of screening for glaucoma).

Lia Prela (410) 786–0548 (for issues related to the competitive acquisition program (CAP) for part B drugs).

Diane Milstead (410) 786–3355 or Gaysha Brooks (410) 786–9649 (for all other issues).

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on the following issues: interim RVUs for selected procedure codes identified in Addendum C; and the physician self referral designated health services listed in tables 32 and 33. You can assist us by referencing the file code CMS–1502-FC and the specific ''issue identifier'' that precedes the section on which you choose to comment.

Inspection of Public Comments: All comments received before the close of

the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. CMS posts all comments received before the close of the comment period on its public web site as soon as possible after they are received. Hard copy comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

This **Federal Register** document is also available from the **Federal Register** online database through GPO Access a service of the U.S. Government Printing Office. The web site address is: *http://www.access.gpo.gov/nara/index.html*.

Information on the physician fee schedule can be found on the CMS homepage. You can access this data by using the following directions:

1. Go to the CMS homepage (*http://www.cms.hhs.gov*).

2. Place your cursor over the word ''Professionals'' in the blue areas near the top of the page. Select ''physicians'' from the drop-down menu.

3. Under ''Billing/Payment'' select ''Physician Fee Schedule''.

To assist readers in referencing sections contained in this preamble, we are providing the following table of contents. Some of the issues discussed in this preamble affect the payment policies, but do not require changes to the regulations in the *Code of Federal Regulations.* Information on the regulation's impact appears throughout the preamble and is not exclusively in section VI.

Table of Contents

In addition, because of the many organizations and terms to which we refer by acronym in this proposed final rule with comment, we are listing these acronyms and their corresponding terms in alphabetical order below:

AADA American Academy of Dermatology Association
AAH American Association for Homecare
ABN Advanced Beneficiary Notice
ACC American College of Cardiology
ACG American College of Gastroenterology
ACR American College of Radiology
AFROC Association of Freestanding Radiation Oncology Centers
AGA American Gastroenterological Association
AMA American Medical Association
AMP Average manufacturer price
AOAO American Osteopathic Academy of Orthopedics
ASA American Society of Anesthesiologists
ASGE American Society of Gastrointestinal Endoscopy
ASP Average sales price
ASTRO American Society for Therapeutic Radiation Oncology
AUA American Urological Association
AWP Average wholesale price
BBA Balanced Budget Act of 1997
BBRA Balanced Budget Refinement Act of 1999
BIPA Benefits Improvement and Protection Act of 2000
BLS Bureau of Labor Statistics
BMI Body mass index
BNF Budget neutrality factor
BSA Body surface area
CAP Competitive Acquisition Program
CBSA Core-Based Statistical Area
CF Conversion factor
CFR Code of Federal Regulations
CMA California Medical Association
CMS Centers for Medicare & Medicaid Services
CNS Clinical nurse specialist
COBC Coordination of Benefits Contractor
CPEP Clinical Practice Expert Panel
CPI Consumer Price Index
CPO Care Plan Oversight
CPT (Physicians') Current Procedural Terminology (4th Edition, 2002, copyrighted by the American Medical Association)
CRNA Certified Registered Nurse Anesthetist
CT Computed tomography
CTA Computed tomographic angiography
CY Calendar year
DAW Dispense as written
DHS Designated health services
DME Durable medical equipment
DMERC Durable Medical Equipment Regional Carrier
DSMT Diabetes outpatient self-management training services
EAC Estimated acquisition cost
ECP External counterpulsation
E/M Evaluation and management
EPO Erythopoeitin
ESRD End stage renal disease
FAX Facsimile
FDA Food and Drug Administration
FI Fiscal intermediary
FQHC Federally qualified health center
FR **Federal Register**
GAF Geographic adjustment factor
GAO Government Accountability Office
GPCI Geographic practice cost index
GPOs Group Purchasing Organizations
HCPAC Health Care Professional Advisory Committee
HCPCS Healthcare Common Procedure Coding System
HHA Home health agency
HHS (Department of) Health and Human Services
HIC Health Insurance Number
HIPAA Health Insurance Portability and Accountability Act of 1996, Public Law 104–191
HOCM High Osmolar Contrast Media
HPSA Health professional shortage area
HRSA Health Resources and Services Administration (HHS)
IDTFs Independent diagnostic testing facilities
IPF Inpatient psychiatric facility
IPPS Inpatient prospective payment system
IRF Inpatient rehabilitation facility
ISO Insurance Services Office
IVIG Intravenous immune globulin
JCAAI Joint Council of Allergy, Asthma, and Immunology
JUA Joint underwriting association
LCD Local coverage determination
LTCH Long-term care hospital
LOCM Low Osmolar Contrast Media
MA Medicare Advantage
MCAC Medicare Coverage Advisory Committee
MCG Medical College of Georgia
MedPAC Medicare Payment Advisory Commission
MEI Medicare Economic Index
MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MNT Medical nutrition therapy
MRA Magnetic resonance angiography
MRI Magnetic resonance imaging
MSA Metropolitan statistical area
MSN Medicare summary notice
NCD National coverage determination
NCQDIS National Coalition of Quality Diagnostic Imaging Services
NDC National drug code
NECMA New England County Metropolitan Area
NECTA New England City and Town Area
NP Nurse practitioner
NPP Nonphysician practitioners
NPWP Nonphysician work pool
OBRA Omnibus Budget Reconciliation Act
OIG Office of Inspector General
OMB Office of Management and Budget
OPPS Outpatient prospective payment system
OT Occupational therapy
PA Physician assistant
PC Professional component
PE Practice Expense
PEAC Practice Expense Advisory Committee
PERC Practice Expense Review Committee
PET Positron emission tomography
PFS Physician Fee Schedule
PLI Professional liability insurance
PPAC Practicing Physicians Advisory Council
PIN Provider identification number
PPI Producer price index
PPO Preferred provider organization
PPS Prospective payment system
PRA Paperwork Reduction Act
PT Physical therapy
RFA Regulatory Flexibility Act
RIA Regulatory impact analysis
RN Registered nurse
RUC (AMA's Specialty Society) Relative (Value) Update Committee
RVU Relative value unit
SGR Sustainable growth rate
SMS (AMA's) Socioeconomic Monitoring System
SNF Skilled nursing facility
SNM Society for Nuclear Medicine
TA Technology assessment
TC Technical component
TEB Thoracic electrical bioimpedance
tPA Tissue-type plasminogen activator
UAF Update adjustment factor
UPIN Unique provider identification number
WAC Wholesale acquisition cost
WAMP Widely available market price

I. Background

A. Introduction

Since January 1, 1992, Medicare has paid for physicians' services under section 1848 of the Social Security Act (the Act), ''Payment for Physicians' Services.'' The Act requires that payments under the physician fee schedule (PFS) be based on national uniform relative value units (RVUs) based on the resources used in furnishing a service. Section 1848(c) of the Act requires that national RVUs be established for physician work, practice expense (PE), and malpractice expense. Prior to the establishment of the

resource-based relative value system, Medicare payment for physicians' services was based on reasonable charges.

Section 1848(c)(2)(B)(ii)(II) of the Act provides that adjustments in RVUs may not cause total physician fee schedule payments to differ by more than $20 million from what they would have been had the adjustments not been made. If adjustments to RVUs cause expenditures to change by more than $20 million, we must make adjustments to ensure that they do not increase or decrease by more than $20 million.

B. Development of the Relative Value System

1. Work RVUs

The concepts and methodology underlying the PFS were enacted as part of the Omnibus Budget Reconciliation Act (OBRA) of 1989, Public Law 101–239, and OBRA 1990, (Public Law 101–508). The final rule published November 25, 1991 (56 FR 59502) set forth the fee schedule for payment for physicians' services beginning January 1, 1992. Initially, only the physician work RVUs were resource-based, and the PE and malpractice RVUs were based on average allowable charges.

The physician work RVUs established for the implementation of the fee schedule in January 1992 were developed with extensive input from the physician community. A research team at the Harvard School of Public Health developed the original physician work RVUs for most codes in a cooperative agreement with the Department of Health and Human Services (HHS). In constructing the code-specific vignettes for the original physician work RVUs, Harvard worked with panels of experts, both inside and outside the government, and obtained input from numerous physician specialty groups.

Section 1848(b)(2)(A) of the Act specifies that the RVUs for radiology services are based on a relative value scale we adopted under section 1834(b)(1)(A) of the Act, (the American College of Radiology (ACR) relative value scale), which we integrated into the overall PFS. Section 1848(b)(2)(B) of the Act specifies that the RVUs for anesthesia services are based on RVUs from a uniform relative value guide. We established a separate conversion factor (CF) for anesthesia services, and we continue to utilize time units as a basis for determining payment for these services. As a result, there is a separate payment methodology for anesthesia services.

We establish physician work RVUs for new and revised codes based on recommendations received from the American Medical Association's (AMA) Specialty Society Relative Value Update Committee (RUC).

2. Practice Expense Relative Value Units (PE RVUs)

Section 121 of the Social Security Act Amendments of 1994 (Pub. L. 103–432), enacted on October 31, 1994, amended section 1848(c)(2)(C)(ii) of the Act and required us to develop resource-based PE RVUs for each physician's service beginning in 1998. We were to consider the staff, equipment, and supplies used in the provision of various medical and surgical services. The legislation specifically required that, in implementing the new system of PE RVUs, we apply the same budget-neutrality provisions that are applicable to other adjustments under the physician fee schedule.

Section 4505(a) of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33), amended section 1848(c)(2)(C)(ii) of the Act to delay implementation of the resource-based PE RVU system until January 1, 1999. In addition, section 4505(b) of the BBA provided for a 4-year transition period from charge-based PE RVUs to resource-based RVUs.

We established the resource-based PE RVUs for each physician's service in a final rule, published November 2, 1998 (63 FR 58814), effective for services furnished in 1999. Based on the requirement to transition to a resource-based system for PE over a 4-year period, resource-based PE RVUs did not become fully effective until 2002.

This resource-based system was based on two significant sources of actual PE data: The Clinical Practice Expert Panel (CPEP) data and the AMA's Socioeconomic Monitoring System (SMS) data. The CPEP data were collected from panels of physicians, practice administrators, and nonphysicians (for example, registered nurses) nominated by physician specialty societies and other groups. The CPEP panels identified the direct inputs required for each physician's service in both the office setting and out-of-office setting. The AMA's SMS data provided aggregate specialty-specific information on hours worked and PEs.

Separate PE RVUs are established for procedures that can be performed in both a nonfacility setting, such as a physician's office, and a facility setting, such as a hospital outpatient department. The difference between the facility and nonfacility RVUs reflects the fact that a facility receives separate payment from Medicare for its costs of providing the service, apart from payment under the PFS. The nonfacility RVUs reflect all of the direct and indirect PEs of providing a particular service outside a facility setting.

Section 212 of the Medicare, Medicaid and State Child Health Insurance Program Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113) directed the Secretary to establish a process under which we accept and use, to the maximum extent practicable and consistent with sound data practices, data collected or developed by entities and organizations to supplement the data we normally collect in determining the PE component. On May 3, 2000, we published the interim final rule (65 FR 25664) that set forth the criteria for the submission of these supplemental PE survey data. The criteria were modified in response to comments received, and published in the **Federal Register** (65 FR 65376) as part of the November 1, 2000 final rule. The PFS final rules published in 2001 and 2003, respectively, (66 FR 55246 and 68 FR 63196) extended the period during which we would accept these supplemental data.

As discussed in the January 7, 2004 physician fee schedule final rule (69 FR 1092), section 303(a)(1)(B) of MMA amended section 1848(c)(2) of the Act by adding new subparagraph (H), ''Adjustments in Practice Expense Relative Value Units for Certain Drug Administration Services beginning in 2004''. Subparagraph (H)(i) requires the Secretary to determine the practice expense RVUs for 2004 using practice expense surveys submitted to the Secretary as of January 1, 2003 by a physician specialty organization in accordance with section 212 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (BBRA) of 1999 if the survey: (1) Covers practice expenses for oncology drug administration services; and (2) meets criteria established by the Secretary for acceptance of such surveys. Consistent with section 1848(c)(2)(H)(i) of the Act, in January 7, 2005 final rule, we announced we would use the ASCO survey to determine the practice expense RVUs for physician fee schedule services furnished on or after January 1, 2004 because it: (1) Was submitted prior to January 1, 2003; (2) includes expenses for drug administration services; and (3) meets criteria we have established for use of surveys.

3. Resource-Based Malpractice RVUs

Section 4505(f) of the BBA amended section 1848(c) of the Act to require us to implement resource-based malpractice RVUs for services furnished on or after 2000. The resource-based malpractice RVUs were implemented in the PFS final rule published November 2, 1999 (64 FR 59380). The malpractice RVUs are based on malpractice insurance premium data collected from commercial and physician-owned insurers from all the States, the District of Columbia, and Puerto Rico.

4. Refinements to the RVUs

Section 1848(c)(2)(B)(i) of the Act requires that we review all RVUs no less often than every five years. The first 5-year review of the physician work RVUs went into effect in 1997, published on November 22, 1996 (61 FR 59489). The second 5-year review went into effect in 2002, published on November 1, 2001 (66 FR 55246). The next 5-year review is scheduled to go into effect in 2007.

In 1999, the AMA's RUC established the Practice Expense Advisory Committee (PEAC) for the purpose of refining the direct PE inputs. Through March of 2004, the PEAC provided recommendations to CMS for over 7,600 codes (all but a few hundred of the codes currently listed in the AMA's Current Procedural Terminology (CPT) codes).

In the November 15, 2004, PFS final rule (69 FR 66236), hereinafter referred to as the CY 2005 final rule, we implemented the first 5-year review of the malpractice RVUs (69 FR 66263).

5. Adjustments to RVUS Are Budget Neutral

Section 1848(c)(2)(B)(ii)(II) of the Act provides that adjustments in RVUs for a year may not cause total PFS payments to differ by more than $20 million from what they would have been if the adjustments were not made. In accordance with section 1848(c)(2)(B)(ii)(II) of the Act, if adjustments to RVUs cause expenditures to change by more than $20 million, we make adjustments to ensure that expenditures do not increase or decrease by more than $20 million.

C. Components of the Fee Schedule Payment Amounts

Under the formula set forth in section 1848(b)(1) of the Act, the payment amount for each service paid under the physician fee schedule is the product of three factors: (1) A nationally uniform relative value unit (RVU) for the service; (2) a geographic adjustment factor (GAF) for each physician fee schedule area; and (3) a nationally uniform conversion factor (CF) for the service. The CF converts the relative values into payment amounts.

For each physician fee schedule service, there are 3 relative values: (1) An RVU for physician work; (2) an RVU for practice expense; and (3) an RVU for malpractice expense. For each of these components of the fee schedule, there is a geographic practice cost index (GPCI) for each fee schedule area.

To calculate the payment for every physician service, the components of the fee schedule (physician work, PE, and malpractice RVUs) are adjusted by a geographic practice cost index (GPCI). The GPCIs reflect the relative costs of physician work, PEs, and malpractice insurance in an area compared to the national average costs for each component.

Payments are converted to dollar amounts through the application of a CF, which is calculated by the Office of the Actuary and is updated annually for inflation.

The general formula for calculating the Medicare fee schedule amount for a given service and fee schedule area can be expressed as:

Payment = [(RVU work × GPCI work) + (RVU PE × GPCI PE) + (RVU malpractice × GPCI malpractice)] × CF.

The CF for calendar year (CY) 2005 appears in section VI, Physician Fee Schedule Update for CY 2006. The RVUs for CY 2006 are in Addendum B. The GPCIs for CY 2006 can be found in Addendum D.

Section 1848(e) of the Act requires us to develop GAFs for all physician fee schedule areas. The total GAF for a fee schedule area is equal to a weighted average of the individual GPCIs for each of the three components of the service. However, in accordance with the statute, the GAF for the physician's work reflects one-quarter of the relative cost of physician's work compared to the national average.

D. Most Recent Changes to the Fee Schedule

In the CY 2005 final rule (69 FR 66236), we refined the resource-based PE RVUs and made other changes and clarifications to Medicare Part B payment policy. These included:

- Supplemental survey data for PE;
- Updated GPCIs for physician work and PE;
- Updated malpractice RVUs;
- Revised requirements for supervision of therapy assistants;
- Revised payment rules for low osmolar contrast media (LOCM);
- Payment policies for physicians and practitioners managing dialysis patients;
- Clarification of care plan oversight (CPO) requirements;
- Requirements for supervision of diagnostic psychological testing services;
- Clarifications to the policies affecting therapy services provided incident to a physician's service;
- Requirements for assignment of Medicare claims;
- Additions to the list of telehealth services;
- Changes to payments for drug administration services; and
- Several coding issues.

The CY 2005 final rule (69 FR 66236) also addressed the following provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173):

- Coverage of an initial preventive physical examination.
- Coverage of cardiovascular screening blood tests.
- Coverage of diabetes screening tests.
- Incentive payment improvements for physicians in physician shortage areas.
- Changes to payment for covered outpatient drugs and biologicals and drug administration services.
- Changes to payment for renal dialysis services.
- Coverage of routine costs associated with certain clinical trials of category A devices as defined by the Food and Drug Administration.
- Coverage of hospice consultation service.
- Indexing the Part B deductible to inflation.
- Extension of coverage of intravenous immune globulin (IVIG) for the treatment in the home of primary immune deficiency diseases.
- Revisions to reassignment provisions.
- Payment for diagnostic mammograms.
- Coverage of religious nonmedical health care institution items and services to the beneficiary's home.

In addition, the CY 2005 PFS final rule finalized the calendar year (CY) 2004 interim RVUs for new and revised codes in effect during CY 2004 and issued interim RVUs for new and revised procedure codes for CY 2005; updated the codes subject to the physician self-referral prohibition; discussed payment for set up of portable x-ray equipment; discussed the third 5-year refinement of work RVUs; and solicited comments on potentially misvalued work RVUs.

In accordance with section 1848(d)(1)(E) of the Act, we also announced that the PFS update for CY 2005 would be 1.5 percent; the initial

estimate for the sustainable growth rate for CY 2005 was 4.3; and the CF for CY 2005 would be $37.8975.

II. Provisions of the Final Rule

In response to the August 8, 2005 proposed rule (70 FR 45764), we received approximately 15,000 comments. We received comments from individual physicians, health care workers, professional associations and societies, and beneficiaries. The majority of the comments addressed the proposals related to PE and the negative update to the PFS, GPCIs, and Teaching Anesthesiology.

The proposed rule discussed policies that affected the RVUs on which payment for certain services would be based and other changes to Medicare Part B payment policy. We also discussed changes related to payment for covered outpatient drugs and biologicals; supplemental payments to federally qualified health centers (FQHCs); payment for renal dialysis services; the national coverage decision (NCD) process; coverage of screening for glaucoma; private contracts; and physician referrals for nuclear medicine services and supplies to health care entities with which they have financial relationships. RVU changes implemented through this final rule with comment are subject to the $20 million limitation on annual adjustments contained in section 1848(c)(2)(B)(ii)(II) of the Act.

After reviewing the comments and determining the policies we would implement, we have estimated the costs and savings of these policies and discuss in detail the effects of these changes in the Regulatory Impact Analysis in section XIV.

For the convenience of the reader, the headings for the policy issues correspond to the headings used in the August 8, 2005 proposed rule. More detailed background information for each issue can be found in the August 8, 2005 proposed rule.

A. Resource Based Practice Expense (PE) RVUs

Based on section 1848(c)(1)(B) of the Act, PEs are the portion of the resources used in furnishing the service that reflects the general categories of physician and practitioner expenses (such as office rent and wages of personnel, but excluding malpractice expenses).

Section 121 of the Social Security Amendments of 1994 (Pub. L. 103–432), enacted on October 31, 1994, required us to develop a methodology for a resource-based system for determining PE RVUs for each physician's service. Up until that point, physicians' PEs were based on historical allowed charges. This legislation stated that the revised PE methodology must consider the staff, equipment, and supplies used in the provision of various medical and surgical services in various settings beginning in 1998. The Secretary has interpreted this to mean that Medicare payments for each service would be based on the relative PE resources typically involved with performing the service.

The initial implementation of resource-based PE RVUs was delayed until January 1, 1999, by section 4505(a) of the BBA. In addition, section 4505(b) of the BBA required the new payment methodology be phased-in over 4 years, effective for services furnished in CY 1999, and fully effective in CY 2002. The first step toward implementation called for by the statute was to adjust the PE values for certain services for CY 1998. Section 4505(d) of BBA required that, in developing the resource-based PE RVUs, the Secretary must:

- Use, to the maximum extent possible, generally accepted cost accounting principles that recognize all staff, equipment, supplies, and expenses, not solely those that can be linked to specific procedures.
- Develop a refinement method to be used during the transition.
- Consider, in the course of notice and comment rulemaking, impact projections that compare new proposed payment amounts to data on actual physician PEs.

Beginning in CY 1999, Medicare began the 4 year transition to resource-based PE RVUs. In CY 2002, the resource-based PE RVUs were fully transitioned.

1. Current Methodology

The following sections discuss the current PE methodology.

a. Data Sources

There are two primary data sources used to calculate PEs. The AMA's SMS survey data are used to develop the PEs per hour for each specialty. The second source of data used to calculate PEs was originally developed by the CPEP. The CPEP data include the supplies, equipment, and staff times specific to each procedure.

The AMA developed the SMS survey in 1981 and discontinued it in 1999. Beginning in 2002, we incorporated the 1999 SMS survey data into our calculation of the PE RVUs, using a 5-year average of SMS survey data. (See Revisions to Payment Policies and Five-Year Review of and Adjustments to the Relative Value Units Under the Physician Fee Schedule for CY 2002 final rule, published November 1, 2001 (66 FR 55246).) The SMS PE survey data are adjusted to a common year, 1995. The SMS data provide the following six categories of PE costs:

- Clinical payroll expenses, which are payroll expenses (including fringe benefits) for clinical nonphysician personnel.
- Administrative payroll expenses, which are payroll expenses (including fringe benefits) for nonphysician personnel involved in administrative, secretarial or clerical activities.
- Office expenses, which include expenses for rent, mortgage interest, depreciation on medical buildings, utilities and telephones.
- Medical material and supply expenses, which include expenses for drugs, x-ray films, and disposable medical products.
- Medical equipment expenses, which include depreciation expenses, leases, and rent of medical equipment used in the diagnosis or treatment of patients.
- All other expenses, including expenses for legal services, accounting, office management, professional association memberships, and any professional expenses not mentioned above.

In accordance with section 212 of the BBRA, we established a process to supplement the SMS data for a specialty with data collected by entities and organizations other than the AMA (that is, the specialty itself). (See the Criteria for Submitting Supplemental Practice Expense Survey Data interim final rule with comment period, published on May 3, 2000 (65 FR 25664).) Originally, the deadline to submit supplementary survey data was through August 1, 2001. This deadline was extended in the November 1, 2001 final rule through August 1, 2003. (See the Revisions to Payment Policies and Five-Year Review of and Adjustments to the Relative Value Units Under the Physician Fee Schedule for CY 2002 final rule, published on November 1, 2001 (66 FR 55246).) Then, to ensure maximum opportunity for specialties to submit supplementary survey data, we extended the deadline to submit surveys until March 1, 2005. (See the Revisions to Payment Policies Under the Physician Fee Schedule for CY 2002 final rule, published on November 7, 2003 (68 FR 63196).)

The CPEPs consisted of panels of physicians, practice administrators, and nonphysicians (registered nurses, for example) who were nominated by physician specialty societies and other groups. There were 15 CPEPs consisting

of 180 members from more than 61 specialties and subspecialties. Approximately 50 percent of the panelists were physicians.

The CPEPs identified specific inputs involved in each physician service provided in an office or facility setting. The inputs identified were the quantity and type of nonphysician labor, medical supplies, and medical equipment.

In 1999, the AMA's Multi-specialty Relative Value Update Committee (RUC) established the PEAC. Since 1999, and until March 2004, the PEAC, a multi-specialty committee, reviewed the original CPEP inputs and provided us with recommendations for refining these direct PE inputs for existing CPT codes. Through its last meeting in March 2004, the PEAC provided recommendations which we have reviewed and accepted for over 7,600 codes. As a result of this scrutiny by the PEAC, the current CPEP/RUC inputs differ markedly from those originally recommended by the CPEPs. The PEAC has now been replaced by the Practice Expense Review Committee (PERC), which acts to assist the RUC in recommending PE inputs.

b. Allocation of Practice Expenses to Services

In order to establish PE RVUs for specific services, it is necessary to establish the direct and indirect PE associated with each service. Our current approach is to allocate aggregate specialty practice costs to specific procedures and, thus, it is often referred to as a ''top-down'' approach. The specialty PEs are derived from the AMA's SMS survey and supplementary survey data. The PEs for a given specialty are allocated to the services performed by that specialty on the basis of the CPEP/RUC data and work RVUs assigned to each CPT code. The specific process is detailed as follows:

Step 1—Calculation of the SMS Cost Pool for Each Specialty

The six SMS cost categories can be described as either direct or indirect expenses. The three direct expense categories include clinical labor, medical supplies and medical equipment. Indirect expenses include administrative labor, office expense, and all other expenses. We combine these indirect expenses into a single category. The SMS cost pool for each specialty is calculated as follows:

- The specialty PE per hour (PE/HR) for each of the three direct and one indirect cost categories from the SMS is calculated by dividing the aggregate PE per specialty by the specialty's total hours spent in patient care activities (also determined by the SMS survey). The PE/HR is divided by 60 to obtain the PE per minute (PE/MIN).
- Each specialty's PE pools (for each of the three direct and one indirect cost categories) are created by multiplying the PE/MIN for the specialty by the total time the specialty spent treating Medicare patients for all procedures (determined using Medicare utilization data). Physician time on a procedure-specific level is available through RUC surveys of new or revised codes and through surveys conducted as part of the 5-year review process. For codes that the RUC has not yet reviewed, the original data from the Harvard resource-based RVU system survey is used. Physician time includes time spent on the case before, during, and after the procedure. The physician procedure time is multiplied by the frequency that each procedure is performed on Medicare patients by the specialty.
- The total specialty-specific SMS PE for each cost category is the sum, for each direct and indirect cost category, of all of the procedure-specific total PEs.

Table 1 illustrates an example of the calculation of the total SMS cost pools for the three direct and one indirect cost categories discussed in step 1. For this specialty, PE/HR for clinical payroll expenses is $9.30 per hour. The hourly rate is divided by 60 minutes to obtain the clinical payroll per minute for the specialty.

The total clinical payroll for providing hypothetical procedure 00001 for this specialty of $3,633,465 is the result of taking the clinical payroll per minute of $0.16; multiplying this by the physician time for procedure 00001 (56 minutes); and multiplying the result by the number of times this procedure was provided to Medicare patients by this specialty (418,602). The total amount spent on clinical payroll in this specialty is $667,457,018. This amount is calculated by summing the clinical payroll expenses of procedure 00001 and all of the other services provided by this specialty.

TABLE 1: Calculation of SMS Cost Pool

Standard Methodology		Clinical Payroll	Medical Supplies	Medical Equipment	Indirect Expenses	Total*
		(A)	(B)	(C)	(D)	(E)
(a)	PE/HR	$9.30	$4.80	$7.40	$46.50	$68.00
(b)	PE/Minute	$0.16	$0.08	$0.12	$0.78	$1.13
(c)	Physician Time - 00001	56	56	56	56	56
(d)	Number of Services	418,602	418,602	418,602	418,602	418,602
(e)	Subtotal	$3,633,465	$1,875,337	$2,891,144	$18,167,327	$26,567,274
(f)	All Other Services	$663,823,552	$342,618,608	$528,203,687	$3,319,117,762	$4,853,763,609
(g)	Total - SMS Pool	$667,457,018	$344,493,945	$531,094,831	$3,337,285,089	$4,880,330,883
	(b) =(a)/60					
	(e) =(b)*(c)*(d)					
	(g) =(e)+(f)					

* Components may not add to totals due to rounding.

Step 2—Calculation of CPEP Cost Pool

CPEP data provide expenditure amounts for the direct expense categories (clinical labor, supplies, and equipment cost) at the procedure level. Multiplying the CPEP procedure-level PEs for each of these three categories by the number of times the specialty provided the procedure, produces a total category cost, per procedure, for that specialty. The sum of the total expenses from each procedure results in the total CPEP category cost for the specialty.

For example, in Table 2, using CPEP data, the clinical labor cost of procedure 00001 is $65.23. Under the methodology described above in this step, this is multiplied by the number of services for the specialty (418,602), to yield the total CPEP data clinical labor cost of the procedure: $27,305,408. In this example, the clinical labor cost for all other services performed by this specialty is $831,618,600. Therefore, the entire clinical labor CPEP expense pool for the specialty is $858,924,008. Step 2 is repeated to calculate the CPEP supply and equipment costs.

TABLE 2: Calculation of CPEP Cost Pool

	Standard Methodology	Clinical Labor	Supplies	Equipment
		(A)	(B)	(C)
(a)	CPT 00001	$65.23	$52.49	$1,556.86
(b)	Allowed Services	418,602	418,602	418,602
(c)	Subtotal	$27,305,408	$21,972,838	$651,704,875
(d)	All Other Services	$831,618,600	$389,921,779	$5,277,570,148
(e)	Total CPEP Pool	$858,924,008	$411,894,617	$5,929,275,023
	(c) = (a)*(b)			
	(e) = (c) + (d)			

Step 3—Calculation and Application of Scaling Factors

This step ensures that the total of the CPEP costs across all procedures performed by the specialty equates with the total direct costs for the specialty as reflected by the SMS data. To accomplish this, the CPEP data are scaled to SMS data by means of a scaling factor so that the total CPEP costs for each specialty equals the total SMS cost for the specialty. (The scaling factor is calculated by dividing the specialty's SMS pool by the specialty's CPEP pool.)

The unscaled CPEP cost per procedure value, at the direct cost level, is then multiplied by the respective specialty scalar to yield the scaled CPEP procedure value. The sum of the scaled CPEP direct cost pool expenditures equals the total scaled direct expense for the specific procedure at the specialty level.

In the Step 3 example shown in Table 3, the SMS total clinical labor costs for the specialty is $667,457,018. This amount divided by the CPEP total clinical labor amount of $858,924,008 yields a scaling factor of 0.78. The CPEP clinical labor cost for hypothetical procedure 00001 is $65.23. Multiplying the 0.78 scaling factor for clinical labor costs by $65.23 yields the scaled clinical labor cost amount of $50.69. Individual scaling factors must also be calculated for supply and equipment expenses. The sum of the scaled direct cost values, $50.69, $43.90, and $139.45, respectively, equals the total scaled direct expense of $234.04.

TABLE 3.—CALCULATION AND APPLICATION OF SCALING FACTORS

Standard methodology	Clinical/Labor (A)	Supplies (B)	Equipment (C)	Total Scaled direct expense (Sum of A, B, and C) (D)
(a) Total—SMS Pool	$667,457,018	$344,493,945	$531,094,831	
(b) Total—CPEP Pool	858,924,008	411,894,617	5,929,275,023	
(c) Scaling Factor	0.78	52.49	1,556.86	
Unscaled Value				
(e) CPT 00001—Scaled Value	50.69	43.90	139.45	$234.04
(c) = (a)/(b)				
(e) = (c)*(d)				

Step 4—Calculation of Indirect Expenses

Indirect PEs cannot be directly attributed to a specific service because they are incurred by the practice as a whole. Indirect costs include rent, utilities, office equipment and supplies, and accounting and legal fees. There is not a single, universally accepted approach for allocating indirect practice costs to individual procedure codes. Rather allocation involves judgment in identifying the base or bases that are the best measures of a practice's indirect costs.

To allocate the indirect PEs to a specific service, we use the following methodology:

- The total scaled direct expenses and the converted work RVU (the work RVU for the service is multiplied by $34.5030, the 1995 CF) are added together, and then multiplied by the number of services provided by the specialty to Medicare patients.
- The total indirect PEs per specialty are calculated by summing the indirect expenses for all other procedures provided by that specialty.

For example, in Table 4, the physician work RVU for procedure 00001 is 2.36. Multiplying the work RVU by the 1995 CF of $34.5030 equals $81.43. The physician work value is added to the scaled total direct expense from Step 3

($234.04). The total of $314.47 is a proxy for the indirect PE for the specialty attributed to this procedure. The total indirect expenses are then multiplied by the number of times procedure 00001 is provided by the specialty (418,602), to calculate total indirect expenses for this procedure of $132,055,728. The process is repeated across all procedures performed by the specialty, and the indirect expenses for each service are summed to arrive at the total specialty indirect PE pool of $6,745,545,434.

TABLE 4.—CALCULATION OF INDIRECT EXPENSE

Standard Methodology	Physician Work* (A)	Total direct expense (B)	Total (C)
(a) CPT 00001	$81.43	$234.04	$315.47
(b) Allowed Services	.....	.....	418,602
(c) Subtotal	.....	.....	132,055,728
(d) All Other Services	.....	.....	6,613,489,706
(e) Total Indirect Expense	.....	.....	6,745,545,434

*Calculated by multiplying work RVU of 2.36 by 1995 CF of $34.5030.

Step 5—Calculation and Application of Indirect Scaling Factors

Similar to the direct costs, the indirect costs are scaled to ensure that the total across all procedures performed by the specialty equates with the total indirect costs for the specialty as reflected by the SMS data. To accomplish this, the indirect costs calculated in Step 4 (Table 4) are scaled to SMS data. The calculation of the indirect scaling factors is as follows:

- The specialty's total SMS indirect expense pool is divided by the specialty's total indirect expense pool calculated in Step 4 (Table 4), to yield the indirect expense scaling factor.
- The unscaled indirect expense amount, at the procedure level, is multiplied by the specialty's scaling factor to calculate the procedure's scaled indirect expenses.
- The sum of the scaled indirect expense amount and the procedure's direct expenses yields the total PEs for the specialty for this procedure.

In table 5, to calculate the indirect scaling factor for hypothetical procedure 00001, divide the total SMS indirect pool, $3,337,285,089 (calculated in Step 1-Table 1)), by the total indirect expense for the specialty across all procedures of $6,745,545,434. This results in a scaling factor of 0.49. Next, the unscaled indirect cost of $315.47 is multiplied by the 0.49 scaling factor, resulting in scaled indirect cost of $156.07. To calculate the total PEs for the specialty for procedure 00001, the scaled direct and indirect expenses are added, totaling $390.12.

TABLE 5.—CALCULATION OF INDIRECT SCALING FACTORS AND TOTAL PRACTICE EXPENSES

Standard methodology	Indirect costs (A)	Direct cost (B)	Specialty specific practice expenses (Sum of A, B) (C)
(a) Total—SMS Indirect Expense	$3,337,285,089		
(b) Total Indirect Expense for all Procedures (from Step 4)	6,745,545,434		
(c) Scaling Factor	0.49		
(d) CPT 00001—Unscaled Value	315.47		
(e) CPT 00001—Scaled Value	156.07	$234.04	$390.12

Step 6—Weighted Average of RVUs for Procedures Performed by More Than One Specialty

For codes that are performed by more than one specialty, a weighted-average PE is calculated based on Medicare frequency data of all specialties performing the procedure as shown in Table 6.

TABLE 6.—WEIGHT AVERAGING FOR ALL SPECIALTIES

Standard methodology	Practice expense value (A)	Percent of total allowed services (B)
(a) Specialty Total Practice Expense	$390.12	83
(b) Weighted Avg.—All Other Specialties	929.87	17
(c) Weighted Avg.—All Specialties	481.70	100

Step 7—Budget Neutrality and Final RVU Calculation

The total scaled direct and indirect inputs are then adjusted by a budget neutrality factor (BNF) to calculate RVUs. Section 1848(c)(2)(B)(ii)(II) of the Act provides that adjustments in RVUs may not cause total PFS payments to differ by more than $20 million from what they would have been if the adjustments were not made. Budget neutrality for the upcoming year is determined relative to the sum of PE RVUs for the current year. Although the PE RVUs for any particular code may vary from year-to-year, the sum of PE RVUs across all codes is set equal to the current year. The BNF is equal to the sum of the current year's PE RVUs, divided by the sum of the direct and indirect inputs across all codes for the upcoming year. The BNF is applied to (multiplied by) the scaled direct and indirect expenses for each code to set the PE RVU for the upcoming year.

In Table 7, the sum of the scaled direct and indirect expenses for hypothetical code 00001 ($481.70) is multiplied by the BNF (0.02 in this example) to yield a PE RVU of 10.60.

TABLE 7.—CALCULATE PE RVU

	Total scaled direct and indirect inputs (A)	Budget neutrality factor (B)	Final PE RVU (C)
(a) Code 00001	$481.70	0.02	10.60

c. Other Methodological Issues: Nonphysician Work Pool (NPWP)

As an interim measure, until we could further analyze the effect of the top-down methodology on the Medicare payment for services with no physician work (including the technical components (TCs) of radiation oncology, radiology and other diagnostic tests), we created a separate PE pool for these services. However, any specialty society could request that its services be removed from the nonphysician work pool (NPWP). We have removed some services from the NPWP if we find that the requesting specialty provides the service the majority of the time.

NPWP Step 1—Calculation of the SMS Cost Pool for Each Code

This step parallels the calculations described above for the standard ''top-down'' PE allocation methodology. For codes in the NPWP, the direct and indirect SMS costs are set equal to the weighted average of the PE/HR for the specialties that provide the services in the pool. Clinical staff time is substituted for physician time in the calculation. The clinical staff time for the code is from CPEP data. Otherwise, the calculation is similar to the method described previously for codes with physician time.

The following example in Table 8 illustrates this calculation for hypothetical code 00002. In this example, the average clinical payroll PE/HR for all specialties in the NPWP is $12.30 and the clinical staff time for code 00002 is 116 minutes.

TABLE 8: Calculate SMS Cost Pools for Nonphysician Work Pool

Non-Physician Work Pool Methodology (NPWP)		Clinical Payroll (A)	Medical Supplies (B)	Medical Equipment (C)	Indirect Expenses (D)	Total* (E)
(a)	NPWP - PE/HR	$12.30	$7.40	$3.20	$46.30	$69.00
(b)	NPWP - PE/Minute	$0.21	$0.12	$0.05	$0.77	$1.15
(c)	Clinical Staff Time - 00002	116	116	116	116	116
(d)	Number of Services	105,095	105,095	105,095	105,095	105,095
(e)	Total - NPWP "SMS" Pool	$2,499,159	$1,503,559	$650,188	$9,407,404	$14,019,673
	(b) =(a)/60					
	(e) =(b)*(c)*(d)					

* Components may not add to totals due to rounding.

NPWP Step 2—Calculation of Charge-Based PE RVU Cost Pool

The NPWP calculation uses the 1998 (charge-based) PE RVU value for the code, multiplied by the 1995 CF (25.74 × $34.503 = $888.11). The percentage of clinical labor, supplies and equipment are the percentage that each PE category represents for all physicians relative to the total PE for all physicians (calculated from the SMS data) as shown in Table 9.

TABLE 9: Calculate Charge-Based Cost Pools for Nonphysician Work Pool

	NPWP Methodology	Clinical	Supplies	Equipment
		(A)	(B)	(C)
(a)	CPT 00002 - Charge Based Value	$888.11	$888.11	$888.11
(b)	Percent Clinical, Supplies, Equipment	0.18	0.11	0.05
(c)	CPT 00002	$158.08	$95.03	$41.74
(d)	Number of - NPWP	105,095	105,095	105,095
(e)	Total NPWP "CPEP" Pool	$16,613,742	$4,386,775	$9,986,912
	(c) = (a)*(b)			
	(e) = (c)*(d)			

NPWP Step 3—Calculation and Application of Scaling Factors

After the total cost pools for each code in the NPWP are calculated, the steps to ensure the total charge-based PEs for the procedure do not exceed the total SMS PEs for the procedure (scaling) are the same as those described previously for codes with physician work.

In Table 10, the SMS total clinical labor costs are $2,499,159. This amount divided by the charge-based total clinical labor amount of $16,613,742 yields a scaling factor of 0.15. The charge-based clinical labor cost for hypothetical procedure 00002 is $158.08 (from NPWP Step 2—Table 9). Multiplying the 0.15 scaling factor for clinical labor costs by $158.08 yields the scaled clinical labor cost amount of $23.78. Individual scaling factors must be calculated for both supply and equipment expenses. The sum of the scaled direct cost values, $23.78, $32.57 and $2.72, respectively, equals the total scaled direct expense of $59.07.

TABLE 10.—CALCULATION AND APPLICATION OF DIRECT COST SCALING FACTORS

NPWP methodology	Clinical (A)	Supplies (B)	Equipment (C)	Total scaled direct expense (Sum of A, B, and C) (D)
(a) Total—NPWP Specialty Pool	$2,499,159	$1,503,559	$650,188	
(b) Total NPWP Charge-based Pool	16,613,742	4,386,775	9,986,912	
(c) Scaling Factor	0.15	0.34	0.06	
(d) CPT 00002—Unscaled Value	158.08	95.03	41.74	
(e) CPT 00002—Scaled Value	23.78	32.57	2.72	$59.07

NPWP Step 4—Calculation of Indirect Expenses

Because codes in the NPWP do not have work RVUs, indirect expenses are set equal to direct expenses (for codes with physician work, indirect expenses equal the sum of the scaled direct expenses and the converted work RVU). This amount is then multiplied by the number of times the procedure is performed.

In Table 11, the scaled total direct expense from NPWP Step 3 (Table 10) ($59.07) is also the proxy for the total indirect expense attributed to the procedure. The total indirect expense is multiplied by the number of services (105,095), to calculate total indirect cost for this procedure of $6,207,961.

TABLE 11.—CALCULATION OF INDIRECT EXPENSES

NPWP methodology	Physician work * (A)	Total direct expense (B)	Total (C)
(a) CPT 00002		$59.07	$59.07
(b) Allowed Services—NPWP			105,095
(c) Total NPWP Indirect Expense			$6,207,961

NPWP Step 5—Calculation and Application of Indirect Scaling Factors

Similar to the direct costs, the indirect costs are scaled to ensure that the total of the charge-based PE costs across all procedures equates with the total indirect costs as reflected by the SMS data for the code. To accomplish this, the charge-based indirect PEs are scaled to the SMS indirect PEs.

In Table 12, to calculate the indirect scaling factor for hypothetical procedure 00002, the total SMS indirect PE, $9,407,404 (from NPWP Step 1—Table 8), is divided by the total charge-based indirect expense of $6,207,961 (from NPWP Step 4—Table 11). This results in a scaling factor of 1.51. Next, the

unscaled indirect charge-based cost for procedure 00002 of $59.07 (from NPWP Step 4—Table 11) is multiplied by the 1.51 scaling factor, resulting in scaled indirect costs for this procedure of $89.19.

TABLE 12.—CALCULATION AND APPLICATION OF INDIRECT COST SCALING FACTORS

Standard methodology	Indirect costs (A)	Direct cost (B)	Specialty specific PE RVU (Sum of A and B) (C)
(a) Total—NPWP "SMS" Pool	$9,407,404		
(b) Total NPWP Indirect Expense	6,207,961		
(c) Scaling Factor	1.51		
(d) CPT 00002—Unscaled Value	59.07		
(e) CPT 00002—Scaled Value	89.19	$59.07	$148.26

NPWP Step 6—Budget Neutrality and Final RVU Calculation

Similar to the calculation for codes with physician work, the BNF is applied to (multiplied by) the scaled direct and indirect expenses for each code to set the PE RVU for the upcoming year.

In Table 13, the sum of the scaled direct and indirect expenses for hypothetical code 00002 ($148.26) is multiplied by the BNF (0.022 in this example) to yield a PE RVU of 3.26.

TABLE 13.—BUDGET NEUTRALITY AND FINAL RVU CALCULATION

	Total scaled direct and indirect inputs	Budget neutrality factor	Final PE RVU
Code 00002	$148.26	0.022	2.96

d. Facility/Nonfacility Costs

Procedures that can be performed in a physician's office as well as in a hospital have two PE RVUs; facility and nonfacility. The nonfacility setting includes physicians' offices, patients' homes, freestanding imaging centers, and independent pathology labs. Facility settings include hospitals, ambulatory surgery centers, and skilled nursing facilities (SNFs). The methodology for calculating the PE RVU is the same for both facility and nonfacility RVUs, but each is calculated independently to yield two separate PE RVUs. Because the PEs for services provided in a facility setting are generally included in the payment to the facility (rather than the payment to the physician under the fee schedule), the PE RVUs are generally lower for services provided in the facility setting.

2. PE Proposals for CY 2006

The following discussions outline the specific PE related proposals for CY 2006.

a. Supplemental PE Surveys

The following discussions outline the criteria for supplemental survey submission as well as information we have received for approval.

(1) Survey Criteria and Submission Dates

In accordance with section 212 of the BBRA, we established criteria to evaluate survey data collected by organizations to supplement the SMS survey data normally used in the calculation of the PE component of the PFS. In the final rule published November 7, 2003 (68 FR 63196), we provided that, beginning in 2004, supplemental survey data had to be submitted by March 1 to be considered for use in computing PE RVUs for the following year. This allows us to publish our decisions regarding survey data in the proposed rule and provides the opportunity for public comment on these results before implementation.

To continue to ensure the maximum opportunity for specialties to submit supplemental PE data, we extended until 2005 the period that we would accept survey data that meet the criteria set forth in the November 2000 PFS final rule. The deadline for submission of supplemental data to be considered in CY 2006 was March 1, 2005.

(2) Submission of Supplemental Survey Data

The following discussion outlines the survey data submitted for CY 2004 and CY 2005.

(a) Surveys Submitted in 2004

As discussed in the August 8, 2005 PFS proposed rule (70 FR 45774), we had received surveys by March 1, 2004 from the American College of Cardiology (ACC), the ACR, and the American Society for Therapeutic Radiation Oncology (ASTRO). The data submitted by the ACC and the ACR met our criteria. However, as requested by the ACC and the ACR, we deferred using their data until issues related to the NPWP could be addressed. In the August 8, 2005 proposed rule, we proposed to use the ACC and ACR survey data in the calculation of PE RVUs for CY 2006, but only as specified in the proposals relating to a revised methodology for establishing direct PE RVUs.

The survey data from ASTRO did not meet the precision criteria established for supplemental surveys, therefore, we indicated we would not use it in the calculation of PE RVUs for CY 2005. However, we proposed to use these data to blend with data submitted by the Association of Freestanding Radiation Oncology Centers (AFROC) for CY 2006, as described below.

(b) Surveys Submitted in 2005

In 2005 we received surveys from the AFROC, the American Urological Association (AUA), the American Academy of Dermatology Association (AADA), the Joint Council of Allergy, Asthma, and Immunology (JCAAI), the National Coalition of Quality Diagnostic Imaging Services (NCQDIS) and a joint survey from the American Gastroenterological Association (AGA), the American Society of Gastrointestinal Endoscopy (ASGE), and the American College of Gastroenterology (ACG).

As explained in the August 8, 2005 proposed rule, we contract with the Lewin Group to evaluate whether the supplemental survey data that are submitted meet our criteria and to make recommendations to us regarding their suitability for use in calculating PE RVUs. (The Lewin Group report on the 2005 submissions is available on the CMS Web site at *http://www.cms.hhs.gov/physicians/pfs/*.) The report indicated that, except for the survey from NCQDIS, all met our criteria and we are proposing to accept these surveys. The survey data submitted by the NCQDIS on independent diagnostic testing facilities (IDTFs) did not meet the precision criterion of a 90 percent confidence interval with a range of plus or minus 15 percent of the mean (that is, 1.645 times the standard error of the mean, divided by the mean, is equal to or less than 15 percent of the mean). For the NCQDIS survey, the precision level was calculated at 16.3 percent of the mean PE/HR (weighted by the number of physicians in the practice). However, the Lewin Group has recommended that we accept the data from NCQDIS. The Lewin Group points out that PE data for IDTFs do not currently exist, and suggests that the need for data for the specialty should be weighed against the precision requirement.

We proposed not to accept the NCQDIS data to calculate the PE RVUs for services provided by IDTFs. As just noted, the NCQDIS data did not meet our precision requirements. We established the minimum precision standards because we believe it is necessary to ensure that the data used are valid and reliable, and the consistent application of the precision criteria is the best way to accomplish that objective.

Section 303(a)(1) of the MMA added section 1848(c)(2)(I) of the Act to require us to use survey data that include expenses for the administration of drugs and biologicals submitted by a specialty group for which at least 40 percent of the Part B payments are attributable to the administration of drugs in 2002 to adjust PE RVUs for drug administration services. The provision applies to surveys received by March 1, 2005 for determining the CY 2006 PE RVUs. Section 303(a)(1) of the MMA also amended section 1848(c)(2)(B)(iv)(II) of the Act to provide an exemption from budget neutrality for any additional expenditures resulting from the use of this survey data to adjust PE RVUs for drug administration services. In the Changes to Medicare Payment for Drugs and Physician Fee Schedule Payments for CY 2004 interim final rule published January 7, 2004 (69 FR 1084), we stated that the specialty of urology meets the above criteria, along with gynecology and rheumatology (69 FR 1094). Because we proposed to accept the new survey data from the AUA, we are required to exempt from the budget neutrality adjustment any impacts of accepting these data for purposes of calculating PE RVUs for drug administration services.

In addition, Lewin recommended blending the radiation oncology data from this year's AFROC survey data with last year's ASTRO survey data to calculate the PE/HR. According to the Lewin Group, the goal of the AFROC survey was to represent the population of freestanding radiation oncology centers only. In order to develop an overall average for the radiation oncology PE pool, the Lewin Group recommended we use the AFROC survey for freestanding radiation oncology centers, and the hospital-based subset of last year's ASTRO survey. Consistent with that recommendation, we proposed to use the new PE/HR calculated in this manner for radiation oncology.

As discussed in the August 8, 2005 PFS proposed rule and also in the preamble of this final rule with comment, we proposed to revise our methodology to calculate direct PE RVUs from the current top-down cost allocation methodology to a bottom-up methodology. Although we would continue to use the SMS data and the incorporated supplemental survey data for indirect PEs, we did not extend the deadline for submitting supplemental survey data but rather requested comments on the most appropriate way to proceed to ensure the indirect PEs per hour are accurate and consistent across specialties.

b. Revisions to the PE Methodology

As discussed in the August 8, 2005 proposed rule, since 1997, when we first proposed a resource-based PE methodology, we have had several major goals for this payment system and have encouraged the maximum input from the medical community regarding our PE data and methodology.

We also have had the following three specific goals for the resource-based PE methodology itself, which have also been supported in numerous comments we have received from the medical community:

- To ensure that the PE payments reflect, to the greatest extent possible, the actual relative resources required for each of the services on the PFS. This could only be accomplished by using the best available data to calculate the PE RVUs.
- To develop a payment system for PE that is understandable and at least somewhat intuitive, so that specialties could generally predict the impacts of changes in the PE data.
- To stabilize the PE payments so that there are not large fluctuations in the payment for given procedures from year-to-year.

As we explained in the August 8, 2005 proposed rule, we believe that we have consistently made a good faith effort to ensure fairness in our PE payment system by using the best data available at any one time. The change from the originally proposed ''bottom-up'' to the ''top-down'' methodology came about because of a concern that the resource input data developed in 1995 by the CPEP were less reliable than the aggregate specialty cost data derived from the SMS process. The adoption of the top-down approach necessitated the creation of the NPWP. The NPWP is a separate pool created to allocate PEs for codes that have only a technical (rather than professional) component, or codes that are not performed by physicians.

However, the situation has now changed. As we explained in the August 8, 2005 proposed rule, refinement of the original CPEP data is complete and the refined PE inputs now, in general, accurately capture the relative direct costs of performing PFS services. Also, the major specialties comprising the NPWP (radiology, radiation oncology, and cardiology) submitted supplemental survey data that we proposed to accept, which would eliminate the need to treat these technical services outside the PE methodology applied to other services.

Due to the ongoing refinement by the RUC of the direct PE inputs, we had expected that the PE RVUs would necessarily fluctuate from year-to-year. However, it became apparent that certain aspects of our methodology exacerbated the yearly fluctuations. The services priced by the NPWP methodology have proven to be especially vulnerable to any change in the pool's composition. With the CPEP/RUC refinement of existing services virtually complete, we indicated this was an opportunity for us to propose a way to provide stability to the PE RVUs.

Therefore, consistent with our goals of using the most appropriate data, simplifying our methodology, and increasing the stability of the payment system, we proposed the following changes to our PE methodology and also requested suggestions that would assist us in further refinement of the indirect PE methodology.

(1) Use a Bottom-up Methodology To Calculate Direct PE Costs

Instead of using the top-down approach to calculate the direct PE RVUs, where the aggregate CPEP/RUC costs for each specialty are scaled to match the aggregate SMS costs, we proposed to adopt a bottom-up method of determining the relative direct costs for each service. Under this method, the direct costs would be determined by summing the costs of the resources—the clinical staff, equipment and supplies—typically required to provide the service. The costs of the resources, in turn, would be calculated from the refined CPEP/RUC inputs in our PE database.

(2) Eliminate the Nonphysician Work Pool (NPWP)

Since we proposed to incorporate new survey data for the major specialties that comprise the NPWP, we proposed to eliminate the pool and calculate the PE RVUs for the services currently in the pool by the same methodology used for all other services. This would allow the use of the refined CPEP/RUC data to price the direct costs of individual services, rather than utilizing the pre-1998 charge-based PE RVUs.

(3) Utilize the Current Indirect PE RVUs, Except for Those Services Affected by the Accepted Supplemental Survey Data

As described previously, the SMS and supplemental survey data are the source for the specialty-specific aggregate indirect costs used in our PE calculations. We then allocate to particular codes on the basis of the direct costs allocated to a code and the work RVUs. Although we now believe the CPEP/RUC data are preferable to the SMS data for determining direct costs, we have no information that would indicate that the current indirect PE methodology is inaccurate. We also are not aware of any alternative approaches or data sources that we could use to calculate more appropriately the indirect PE, other than the new supplemental survey data, which we proposed to incorporate into our PE calculations. Therefore, we proposed to use the current indirect PEs in our calculation incorporating the new survey data into the codes performed by the specialities submitting the surveys.

We specifically requested suggestions that would assist us in further refinement of the indirect PE methodology. For example, we noted in the proposed rule that we are considering whether we should continue to accept supplementary survey data or whether it would be preferable and feasible to have an SMS-type survey of only indirect costs for all specialties; or whether a more formula-based methodology independent of the SMS data should be adopted, perhaps using the specialty-specific indirect-to-total cost percentage as a basis of the calculation.

(4) Transition the Resulting Revised PE RVUs Over a 4-Year Period

We are concerned that, when combined with an expected negative update factor for CY 2006, the shifts in some of the PE RVUs resulting from our proposals could cause some measure of financial stress on medical practices. Therefore, we proposed to transition the proposed PE changes over a 4-year period. This would also give ample opportunity for us, as well as the medical specialties and the RUC, to identify any anomalies in the PE data, to make any further appropriate revisions, and to collect additional data, as needed prior to the full implementation of the proposed PE changes.

During this transition period, the PE RVUs would be calculated on the basis of a blend of RVUs calculated using our proposed methodology described above (weighted by 25 percent during CY 2006, 50 percent during CY 2007, 75 percent during CY 2008, and 100 percent thereafter), and the current CY 2005 PE RVUs for each existing code.

Now that the direct PE inputs have been refined, we believe that the CPEP/RUC direct input data are generally superior to the specialty-specific SMS PE/HR data for the purposes of determining the typical direct PE resources required to perform each service on the PFS. First, we have received recommendations on the procedure-specific inputs from the multi-specialty PEAC that were based on presentations from the relevant specialties after being closely scrutinized by the PEAC using standards and packages agreed to by all involved specialties. Second, the refined CPEP/RUC data are more current than the SMS data for the majority of specialties. Third, for direct costs, it appears more accurate to assume that the costs of the clinical staff, supplies and equipment are the same for a given service, regardless of the specialty that is performing it. This assumption does not hold true under the top-down direct cost methodology, where the specialty-specific scaling factors create widely differing costs for the same service.

We also would argue that the proposed methodology is less confusing and more intuitive than the current approach. For instance, the NPWP would be eliminated and all services would be priced using one methodology, eliminating the complicated calculations needed to price NPWP services. Also, any revisions made to the direct inputs would now have predictable results. Changes in the direct practice inputs for a service would proportionately change the PE RVUs for that service without significantly affecting the PE RVUs for unrelated services.

In addition, the proposed methodology would create a system that would be significantly more stable from year-to-year than the current approach. We recognized that there are still some outstanding issues that need further consideration, as well as input from the medical community. For example, although we believe that the elimination of the NPWP would be, on the whole, a positive step, some practitioner services, such as audiology and medical nutrition therapy (MNT), would be significantly impacted by the proposed change. In addition, there are still services, such as the end stage renal disease (ESRD) visit codes, for which we have no direct input information. Also, as mentioned above, we do not have current SMS or supplementary survey data to calculate the indirect costs for most specialties. Further, we do not yet have accurate utilization for the new drug administration codes that were created in response to the MMA provision on drug administration. Therefore, we did not propose to change the RVUs for these services at this time, but to include them under our proposed methodology in next year's rule when we have appropriate data. The proposed transition period would give us the opportunity to work with the affected specialties to collect the needed survey or other data or to determine whether further revisions to our PE methodology are needed.

We requested comments on these proposed changes, particularly those concerning additional modifications to the indirect PE methodology that might help us further our intended goals.

Comment: There were 3 main concerns raised in comments we received on our overall proposed PE methodology which included: (1) Many of the proposed decreases appeared anomalous and were not explained; (2) there was insufficient information given to allow specialties to review and analyze the proposal and its impact; and (3) the use of the new PE data from the seven accepted supplementary surveys caused an inequitable redistribution of PE RVUs. As a result of these concerns, many commenters also requested a

delay in the implementation of our proposed methodology.

The following are examples of the comments detailing the above concerns.

The AMA and the RUC agreed with the goals that we have set for an accurate, intuitive and stable methodology to use for the calculation of PE RVUs. The RUC added that it looks forward to helping us meet these goals. However, the AMA urged us to provide more information, such as examples of how the new values were calculated, the PE/HR and source of the data for each specialty and the budget neutrality adjuster applied at the end of the process, so that the medical community would have the opportunity to review the values and impact of the proposal.

Medicare Payment Advisory Commission (MedPAC) stated its agreement with the concerns regarding the current PE methodology that motivated us to propose a change, but did request that we assess the impact of proposed changes by groups of services—evaluation and management services, major procedures, other procedures, laboratory tests and imaging services, as well as by physician specialty group.

A specialty society representing obstetrics and gynecology commended the goal of the new methodology, but suggested we offer two or more examples of how PE is calculated, starting with the inputs that are used and moving through the process of developing the final PE RVUs for those codes.

An optometric association expressed regret that the proposed rule does not provide service-specific examples of how PE RVUs would be calculated using the current and proposed methodologies because this made it difficult to provide detailed comments on the proposal. Therefore, the commenter concluded that we should issue a final with a comment period. Two emergency medicine societies also requested the same service-specific examples.

An ophthalmology society was troubled by our failure to make the indirect cost data used in determining the rates of change in PE values available to all specialties for review and by the lack of analysis explaining the significant impacts caused by the acceptance of the supplemental survey data.

A specialty society representing cardiology urged us to provide more data and a more detailed explanation of the methodology, along with examples of how RVUs for specific codes were determined, so that stakeholders can gain a thorough understanding of our proposal.

A dermatology association commented that it is pleased that we want to transition to a bottom-up approach. The association believes that this will result in a more easily understood and stable payment system, but it would be helpful to have more information in the final rule on the calculation of PE values under the new methodology. For example, the association asks for clarification of why the PE RVUs for several dermatology procedures decreased.

A specialty society representing physical medicine expressed concern regarding a number of the results with respect to several physical medicine and rehabilitation codes and requested that we provide a more detailed description of the new methodology and address anomalies in the final rule. The commenter suggested that we establish a percentage decrease threshold that would trigger an opportunity for expedited review to determine whether the direct cost inputs are accurate.

Four organizations representing radiation oncology submitted comments stating their concern that several radiation therapy codes, including those for intensity modulated radiation therapy, continuing medical physics consultation and brachytherapy, have inappropriate proposed reductions. Two of the commenters recommended that we examine the impact of the methodology on a code-specific basis and, if necessary, implement an adjustment factor that limits the reduction to no more than 15 percent of the 2005 global RVUs at the end of the 4-year transition period. Comments from societies representing nuclear cardiology and echocardiography also supported a cap on the maximum reduction applied to any procedure that resulted from the decision to adopt the new methodology.

A geriatrics society expressed concern that geriatrics will experience a 1 percent reduction under the new methodology and stated that the transition period is critical, as it will lessen the impact of the proposed reduction. The society suggested that, during the transition period, we should work with stakeholders to explain the new methodology, to identify non-intuitive decreases in payment and to identify better ways to pay for indirect expenses.

An association representing nursing facility medical directors expressed concern that the new methodology will reduce the PE RVUs for nearly all codes for nursing facility services. If we proceed with the changes, the association suggested that we provide a more detailed explanation of the new methodology in the final rule, with examples of the PE RVU calculations for specific services under the old and new methods.

A consulting company expressed concern that we failed to make needed data available, such as the time file, utilization file and scaling factors and pools file. The commenter also requested that, in the future, we consider making available the same files we use to produce the PE RVUs, the assumptions used, such as crosswalks or projected utilization for new services and the data needed to evaluate the methodology used to go from the survey data to a PE/HR.

The American Cancer Society expressed concern regarding the specific reductions in payment for screening mammography, pap smears, pelvic/breast exams and flexible sigmoidoscopies which could potentially reduce access to cancer screenings.

An oncology nursing society strongly urged us to include drug administration services in the phase-in of the new methodology and exempt them from budget neutrality requirements. A cancer and blood disorders center expressed the same concern and stated that this omission would skirt the MMA mandate to exempt from budget neutrality limits any 2006 fee schedule changes to drug administration codes.

An association representing medical colleges noted that, together with the negative update, the decrease in revenue across faculty practice groups will exceed −6 percent. The association recommended that this warrants further review by the medical community and CMS should make public examples of how the new values were calculated, the actual new PE values for each code, the PE per hour and source of the data for each specialty and the budget neutrality adjuster applied as a final step.

A medical technology company requested that we explain how we intend to scale PE when CPT codes, such as endogenous radiofrequency ablation procedures, include a vascular as well as a radiology imaging procedure. The commenter recommended we should calculate the costs according to the primary group furnishing the procedure. In addition, the commenter contended that a deflation factor should not be applied to new procedures that have been valued by the RUC and CMS in late 2004 for establishment of 2005 payment.

Following are examples of the comments explicitly requesting delay.

A comment from specialty societies representing general surgeons, anesthesiology, ophthalmology, hematology, emergency medicine, neurosurgery, cataract surgery, thoracic surgery, orthopaedic surgery, otolaryngology and hand surgery, supported by a letter from a member of the Congress, stated agreement with our goals for a PE methodology. However, the commenters requested that the implementation of the new methodology and data be delayed for 1 year, citing several concerns: First, commenters claimed that CMS did not provide sufficient data and information or time to allow adequate review of the validity of the new methodology, the supplementary survey data or the proposed impact. As a result, the comment argued that physicians have not had a reasonable opportunity to participate in the rule making process, in compliance with the Administrative Procedure Act. In addition, the comment cited the Practicing Physician Advisory Committee recommendation that we delay implementation of the new data and methodology for 1 year.

An oncology society commented that a final decision on the proposed revision to the PE methodology should be deferred 1 year until information is available on how the proposal will affect drug administration services. A large provider of oncology services was also troubled by the decision to exclude drug administration services from revisions to the PE methodology.

A psychological association stated that its primary concern is ''the proposed rule's lack of clarity regarding the impacts that the change in methodology will have on each health care specialty.'' Because of the lack of this data, the Association requested a 1 year delay for our proposal.

A specialty society representing surgeons stated that the proposed methodology apparently created many aberrant PE RVUs and gave examples: Closely related procedures with proposed RVUs that are inconsistent with their actual costs; services that contribute significantly to the increases in volume and intensity noted by MedPAC all receive significant increases; within specialties that should benefit from the higher PE/HR in their surveys, there are increases and decreases that cannot be explained; E/M services will be increased in the office setting, but decreased in the hospital setting. The college recommends that we withdraw the current proposal and republish it in a future PFS rule that includes a detailed description of the methodology.

Two specialty societies representing thoracic and chest physicians expressed concern with the significant shifts in the PE that would necessitate a 4-year transition and suggested that there should be no change in PE until all specialties can complete supplemental PE surveys.

A specialty society representing spine surgeons requested that we suspend the proposed PE changes until 2007, not because the methodology is flawed, but in order to allow all physicians an equal opportunity to submit data relevant to their specialties.

A specialty society representing anesthesiologists contended that lack of information on data and methodology behind the PE changes requires a delay in implementation. The Society requested that we provide information that clearly breaks out the impact of the proposed changes by specialty on the indirect and direct PE payments.

A medical group practice association fully supported the 4-year transition of the new PE values achieved under the new bottom-up calculation. However, because it believed that insufficient information has been made available, the association recommended that we delay implementation until the provider community has time to evaluate the methodology used to recalculate the PE RVUs.

The following commenters requested a delay in calculating the PE RVUs for their own specific services under the new methodology.

Several comments from a specialty society representing heart rhythm services, two manufacturers and a manufacturers association, as well as a provider of remote cardiac monitoring services expressed concern about the proposed cuts for remote cardiac monitoring services and requested that we not implement these proposed reductions, pending further study.

Two societies representing audiology and speech language pathology, supported by a comment from two senators, expressed concern about the large reductions in payment for audiology services and urged us to impose a 1 year moratorium on the proposed reductions for these services so that an equitable methodology for their services can be developed. One commenter suggested that if we do not implement a moratorium on payment decreases for audiology services, we should consider an alternative, such as assigning proxy work RVUs for indirect PE using the otolaryngology PE/HR.

The following commenters opposed any delay in implementing our proposed methodology.

A gastroenterology association commented that, since all medical specialties had equal opportunity to conduct supplemental PE studies, there should not be a delay in the implementation of our proposed changes.

A specialty society representing radiation oncology agreed that more information on the new methodology should be provided, but is opposed to any delay in the implementation of the proposed methodology as the transition provides sufficient opportunity for CMS to provide this information and resolve identified problems.

A sonography society commented that we should not delay the implementation of the revised TC component services with a 4-year transition. An alternative to the zero-work pool has been many years in the making and we should fully implement the new values this year.

An association representing urology disagrees with a 4-year phase in of the revised PE RVUs and strongly urged us to consider other options that will allow specialties with supplemental survey data to realize the full advantages of applying that data in 2006. The commenter claimed that a transition will allow specialties that did not conduct surveys to unfairly take a portion of the 4-year increases from specialties that did.

A specialty society representing allergists expressed concern that the RVUs based on the new accepted data will be phased in over 4 years. The commenter contended that we have not provided any rationale for why we are breaking with past policy or why we have decided to phase-in the specialty survey data. The commenter is concerned in particular about the continued applicability of the old and incorrect scaling factors which result in the discounting of the specialty's costs.

A pharmaceuticals company requested that we consider an immediate 100 percent transition to the 2009 proposed PE values for procedures like photodynamic therapy where access has been constrained due to the use of scaling factors.

A society representing family physicians commented that the original legislation mandating resource-based PE was enacted in 1994 and that we delayed the initial implementation by a year before entering a 4-year transition under our current methodology. The commenter therefore encouraged us to shorten or eliminate the transition and finally complete the process of implementing resource-based PE. However a society representing internists supported our proposal to transition PE RVU changes resulting

from methodological changes in this proposed rule over a 4-year period.

Response: We very much appreciate all the thoughtful and helpful comments we received on our proposal to revise our PE methodology. In addition, we are pleased that so many commenters stated their agreement with the goals that we outlined for our PE methodology in order to implement a payment system for physician and practitioner practice costs that is accurate, understandable, and stable. We also still believe, despite all the concerns pointed out by commenters, that the implementation of a methodology that bases the PE calculations on the latest available data, that uses the PEAC-refined CPEP data to create a bottom-up approach for direct costs and that values all services using the same method will help us achieve those goals.

However, based on the comments we received, it appears that our PE proposal was not as clear and intuitive as we had intended. We continue to believe that the proposal for direct costs was straightforward; this proposal would do away with costs pools and scaling factors and merely add up the costs of the PEAC-refined input data assigned to each code to arrive at the direct PE RVUs (pre-PE budget neutrality). We had not anticipated that our indirect PE calculation would create difficulties since we intended that, except for those services for which the acceptance of the new supplementary survey data produced direct increases, to utilize the current indirect PE RVUs to develop the pre-PE budget neutrality indirect PE RVUs for 2006. However, due to an error in our indirect PE program, the indirect costs were not calculated as intended. As a result, almost all of the PE RVUs published in the August 8, 2005 proposed rule were incorrect.

Therefore, we are concerned that interested parties were not provided notice of the actual effect of the proposed changes in the PE RVU methodology and were not given the sufficient opportunity to submit meaningful comments on the proposal.

As a result, we are withdrawing our entire PE methodology proposal and instead, with only three exceptions, we will use the current 2005 PE RVUs to value all services for CY 2006. First, as we usually do each year, we will value the work and PE on an interim basis for all codes that are new in 2006. Second, as required by section 1848(c)(2)(I) of the Act, we will apply the PE/HR data from the urology supplementary survey to the calculation of the PE RVUs for all the drug administration codes performed by urology. Third, we will apply the savings from the implementation of the multiple procedure payment reduction for certain imaging services across all the PE RVUs that are discussed later in the preamble of this rule.

We understand that the withdrawal of this proposal will be welcomed by some and will be a disappointment to others, especially those specialties that undertook PE surveys that are not being used for 2006. We want to work with the medical community beginning now through the next proposed rule to exchange thoughts on all of the issues raised, to answer any questions and to provide additional data and corrected information. We hope to hold meetings on these topics early next year so that we can obtain maximum input from all interested parties to ensure that our next proposal does meet the goals we have set for our PE methodology.

Acceptance of Supplementary Surveys for 2006

Comment: Many commenters indicated their strong support for our proposal to accept the PE data from 7 supplementary surveys. Several specialty societies representing radiation therapy expressed approval for the proposal to blend the survey data submitted by ASTRO and AFROC to calculate a revised PE/HR for radiation oncology services. A specialty society representing interventional radiology stated support for the proposed use of the ACR's supplemental PE data for purposes of PE RVU determination. The ACC is pleased that we proposed to incorporate their supplemental PE survey data submitted for cardiology and other specialties that submitted data consistent with the acceptance criteria. The ACC commented that, given the rigorous and detailed analysis conducted by our contractor, these data are very likely superior to the SMS data that were used to calculate PE RVUs and that our acceptance of the supplemental PE data has been an important component of efforts to refine the resource-based PE RVUs. An echocardiography society and a commenter representing cardiovascular angiography also stated its support for use of the cardiology data. Two societies representing gastroenterology commented that they are pleased with our acceptance of the supplemental PE survey data for gastroenterology. The AUA strongly urged us to finalize our proposal to accept the AUA's supplemental survey data, as they believe language in the section 303(a)(1)(I) of the MMA requires us to accept supplemental data submitted by urology. In addition, the AUA stated that we are required by the MMA to update the 2006 PE RVUs for urology drug administration, applying the exemption from budget neutrality. A commenter representing prosthetic urology also agreed that we should use the urology supplemental data to allocate the indirect PE costs to each urology procedure.

However, other commenters had concerns with the proposal. An otolaryngology specialty society questioned the validity of the dramatic increases in the PE/HR for the specialties that have submitted surveys because this could create a two-tiered system between those specialties that have submitted surveys and those which have not. Therefore, the society recommended that use of this new PE data be delayed until such time as a multispecialty PE survey can be conducted. A comment from an occupational therapy association recognized the need to use SMS aggregate data in the indirect calculations, but questioned the impact on specialties who did not participate in the survey and suggested that the transition period be used to examine the atypical impact of this change. Two thoracic surgery groups commented that the PE fluctuations and disparities caused by the acceptance of these surveys are counter-intuitive and advantage those for whom we have accepted data at the expense of those from whom we have not. The specialty society representing surgeons stated that the dramatic increase in the proposed PE/HR figures could cause significant distortions in the relativity of PE payments across specialties and urged that we delay implementation of the new data until a multi-specialty PE survey, similar to the AMA's SMS survey can be conducted. However, the society also recommended that we use the urology PE/HR data because it would be required by the MMA. A provider group representing remote cardiac services recommended that we should refrain from incorporating any additional survey data until all supplemental data is submitted.

Conversely, a society representing echocardiographers stated that it is crucial for us to use the submitted survey meeting our criteria in order to retain the type of trust necessary for physician specialty groups to conduct this type of survey in the future. The commenters from the gastroenterology groups stated that use of these data should not be transitioned, but should be treated consistently with the manner in which all other supplemental data have been treated. Further, the commenter contended that, even if we agree to a delay in the implementation

of our proposed methodology, the accepted supplemental PE/HR data should be implemented immediately for both direct and indirect expenses.

Response: We understand the considerable effort, time and money expended by the specialty societies that submitted surveys that met our criteria and are aware that there will be considerable disappointment that the new data will not be used for 2006. We also understand the concern of those specialties that have not undertaken a supplementary survey that now fear that they could be relatively disadvantaged if the accepted surveys are used. We would point out that for the last five years there has been an equal opportunity for all specialties to submit supplementary data and it could be presumed that those specialties that did not avail themselves of the opportunity believed the effort was not worth the probable result. In addition, all specialties had the opportunity to comment on our proposed criteria for acceptance of survey data and the medical community at large did not comment that the criteria needed to be more stringent. However, we will not be using the accepted supplementary data in our indirect PE calculations for 2006, with the exception of the urology PE/HR data that we are applying to the drug administration codes performed by urology as required by section 1848(c)(2)(I) of the Act. We are not using the other accepted supplementary PE data because, as explained above, we are not adopting the proposed changes to our PE methodology, we did not propose to use the survey data for calculating the direct PE RVUs and the use of the survey data would have caused significant changes in the PE RVUs for which there would have been no opportunity for comment.

Comment: We also received several comments with specific concerns regarding our handling of the submitted PE survey data. A specialty society representing radiation oncology asserted that the approach to blending survey data has inadvertently lowered the values for certain radiation oncology services by under-weighting the PE expenses for freestanding facilities from the AFROC survey and by overestimating the hours in the denominator of the PE/HR calculation. In addition, three commenters questioned an apparent discrepancy with the PE/HR for radiology, radiation oncology and cardiology recommended by the Lewin Group and the PE/HR in the proposed rule and the subsequent correction notice. The commenters requested a clarification on how we applied the deflators in order to ensure that all specialties submitting surveys were evaluated in the same way. A comment from specialty societies representing most major surgical groups, as well as emergency medicine and anesthesia, contended that over the years we have treated supplemental survey data with different standards and have blended some while not blending others. A medical technology company requested that we explain how the data were evaluated, especially because we did not accept some recommendations presented by the Lewin Group.

Response: Because we are not utilizing the new supplementary data for indirect PE calculations for 2006, we plan to discuss all of these issues with the relevant specialties in order to determine if adjustments are needed to our calculations of the PE/HR data. However, we do not believe that we have treated supplemental data with different standards, but would request specific information from the commenters. Currently, we are not using any blended data for any supplementary survey that we have accepted and used. Although we rely heavily on the analysis and evaluation of the survey data done by the Lewin Group, we are responsible for the final decision on whether or not to accept the data from a given survey. The Lewin Group did recommend that we accept the data from the NCQDIS survey, which did not meet our precision criteria, because we currently have no survey data for them. However, we believe that it is more equitable to apply the same standards to all who submit surveys and we proposed not to accept the survey data at this time.

Comment: The NCQDIS expressed concern that we did not accept their PE survey data for diagnostic imaging services in IDTFs because the precision criteria was not met. NCQDIS pointed out that the Lewin Group recommended that we accept the data in spite of the precision level because PE data for IDTFs do not currently exist. The commenter stated that, after further analysis of the data, NCQDIS determined that inclusion of one inaccurate record skewed the findings outside the acceptable precision range. Therefore, NCQDIS recommended that we accept the revised analysis from the Lewin Group that includes updated PE information for the record in question and that we allow the updated data to be used in development of PE RVUs for 2006. The NCQDIS recommendation was supported by a comment from a society representing diagnostic medical sonography that contended that no alternative data is available for these entities and the current PE data used understates their PE.

Response: There have been further discussions between NCQDIS and our contractor. We will be discussing this with the specialty in order to resolve the issue for a future proposal.

Comment: A nuclear medicine society stated that it cannot respond to our use of the radiology and cardiology surveys because it has not seen the data as it relates to nuclear medicine. The commenter requested that we make the nuclear medicine supplementary survey information and impact available. A specialty society representing radiation oncology expressed the belief that the new survey data do not reflect the costs of brachytherapy because providers of this service were not adequately represented in the sample.

Response: We would be willing to discuss the societies' concerns to determine an appropriate resolution.

Comment: A long term care association urged us to use the data from the ACR supplementary survey as the PE/HR proxy for the portable x-ray set-up code (Q0092) to prevent inconsistencies in the application of the new payment methodology.

Response: We do not believe it would be appropriate to use the same indirect costs associated with a free-standing radiology center, which incurs costs for such requirements as lead shielding and structural reinforcements for heavy equipment, as the costs for setting up a portable x-ray machine. Therefore, we will not apply the data from the radiology supplementary survey to the calculations of the PE RVUs for Q0092.

Comment: Because we had proposed to accept the supplementary survey data for radiology, radiation oncology and cardiology, the specialties that make up the bulk of the NPWP, we also proposed eliminating the pool and pricing all of the services in the NPWP under the new proposed PE methodology. We received comments from several organizations including those representing diagnostic sonography, urology, medical physicists, allergy geriatrics and a blood disorder center supporting this proposal. However, the specialty society representing audiology urged that, before we dismantle the protection provided by the NPWP, a reasonable formula should be developed to fairly and adequately reimburse audiologists for their services. The societies representing audiology, speech language pathology and medical nutrition all commented that we should assign work RVUs to their services, rather than treating their professional work as PE.

Response: We are pleased that most commenters approved of our proposal to

eliminate the NPWP. However, because we will not be using the accepted new supplementary survey data in the calculation of PE RVUs for 2006, we believe it would be more equitable to defer the elimination of the pool as well. Therefore, we will not be implementing this proposal for 2006. This will also give us the additional time to work with audiology and other specialties to ensure that our future proposal will be equitable to all. Because we are maintaining the NPWP for 2006, we are deferring our decision regarding work RVUs for audiology, speech language pathology and medical nutrition pending further discussions with the specialties.

Bottom-up for Direct PE

Comment: We received many comments on our proposal to value the direct PE for all services by the bottom-up method, using the PEAC refined staff, supply and equipment costs associated with each procedure as the basis for calculating the direct PE RVUs. Almost all of these comments favored our proposal to modify our PE methodology. This support was expressed whether the commenter also requested a delay in the implementation of our proposed methodology or recommended immediate implementation with no transitioning of the new PE RVUs. Commenters who were pleased with the resulting PE RVUs and those concerned with specific reductions also showed support. Below are some specific examples of the supporting comments.

Two comments from specialty societies representing family physicians and internists agreed that the bottom-up approach will produce a more accurate, intuitive and stable PE methodology. One of the commenters contended that the proposed methodology would be more accurate because the bottom-up methodology assumes that the costs of the clinical labor, supplies and equipment are the same for a given service, regardless of the specialty performing it.

A urological association supported switching to a bottom-up methodology for calculating PE RVUs and believed it meets our stated goals of using the most appropriate data, simplifying the PE methodology and increasing the stability of the PE payments.

A major oncology center applauded our decision to implement a bottom-up approach because of the inequities that result when PE RVUs are set using a top-down approach which allows the frequent ''leakage'' of a specialty's costs to other specialties. This rationale was also stated by a society representing anesthesiologists and by a patient advocate foundation.

An oncology nursing society commented it has long advocated a bottom-up modification to help ensure that PE payments reflect the actual relative resources required for each service provided by oncology nurses.

An organization representing allergy supported our proposal to change to a bottom-up methodology for determining PE values because this is a more rational approach. This view was shared in a comment from a physical medicine and rehabilitation society, which added that a bottom-up approach would result in a more direct relationship between PE RVUs and direct costs.

A spine society commented that it welcomed the change to a ''bottom-up methodology because any movement in the direction of stability and uniformity will have positive effects across providers.''

A specialty society representing neurology supported the proposed change to a bottom-up methodology for calculating direct costs. The society asserted that the top-down method is flawed as it unfairly raises the expenses for high-end procedures. The commenter also stated that the excellent work of the PEAC, and now the PERC, has produced reliable data for all the codes, making CPEP complete for all the codes and must be given primacy in any method we would chose to implement.

Two radiation therapy societies stated their strong support of the proposed bottom-up methodology and the proposed implementation for January 1, 2006. One society commented that eliminating the scaling factors, at least for direct costs, is a step in the right direction toward a simpler and more transparent PE methodology.

A respiratory care association stated support for our proposed bottom-up approach because this methodology would minimize aberrations that might inadvertently appear in the calculations, providing a more accurate representation of direct PE incurred by pulmonary physicians.

A psychological association commented that the refinements approved by the PEAC may allow CMS to utilize a more simplified PE methodology which will make PE more understandable.

An organization representing radiology contended that using the bottom-up methodology seems to be a simpler and easier way to make the transition with minimal impact. A medical sonography society stated that our efforts to help ensure a more accurate payment for healthcare services and create more year-to-year stability are to be commended.

An occupational therapy association and a physical therapy association both agreed that the bottom-up method would be a preferable methodology. First, because it would rely on actual inputs from the specialties providing each service and second because it would create a more stable and predictable system and would reflect the actual relative resources required for each service.

A specialty society representing hematology agreed that the top-down method for calculating the direct PE is extremely complex and not at all intuitive and stated that the bottom-up method will simplify the system and reduce the complexity of the calculations.

Other organizations that supported the adoption of the bottom-up approach to valuing direct costs included specialty societies representing podiatry, prosthetic urology, geriatrics, infectious diseases, chest physicians, a pharmaceutical company, and medical group practices.

Response: We are very pleased that so many in the medical community approve of the concept of using a bottom-up methodology to value the direct PE RVUs. We believe, along with these commenters, that the use of the bottom-up approach in the future would allow us to calculate more accurately the relative direct costs for each service in the PFS. The bottom-up approach would be simple to understand—we merely sum the costs of the PEAC-refined clinical staff, supply and equipment inputs that are assigned to each service. The bottom-up approach would be intuitive—any change in direct inputs would lead to a commensurate change in the direct PE RVUs. The bottom-up methodology should also be more stable—with no cost pools or scaling factors to complicate the computation, direct PE RVUs for a service would only change if there was a revision to the inputs assigned. It was the hard work put forth by the AMA, the PEAC, the RUC and specialty societies in refining the CPEP inputs that made it possible to propose using a bottom-up methodology. However, for reasons discussed in this section, we are not implementing the bottom-up methodology for direct costs for 2006. However, we will be working with the RUC and the medical community to ensure that the inputs assigned to each service are correct and that the overall methodology works as intended so that we can propose this improvement in the future.

Comment: Several commenters expressed concern regarding the future refinement of the direct PE inputs that would ensure that a bottom-up methodology continues to lead to appropriate PE RVUs. A radiation oncology specialty society recommended that the bottom-up methodology be reviewed to ensure that the full input amounts are recognized accurately. A specialty society representing podiatry commented that the codes refined in the early stages of the PEAC may have inputs not consistent with codes refined later and that they should be looked at again by PEAC or PERC. The specialty society representing allergy suggested that there needs to be a continuing mechanism, such as the PEAC and PERC, for addressing changes in PE. A physical medicine society asserted that it is essential that we establish a system for updating or revising direct cost inputs based on new data or changes in technology. A thoracic medicine society supported the bottom-up methodology for creating direct PE inputs with continued refinement by the PEAC or the PERC. A pharmaceutical company supported the bottom-up method of determining the relative direct costs of each service, but requested that we establish a system to accept and review external data during the notice and comment period to update the direct cost inputs as needed. A specialty society representing prosthetic urology recommended that we adopt the bottom-up method and establish a method to review external data to ensure that the inputs are updated appropriately.

Response: We agree with the commenters that there needs to be a continuing review process for the direct PE inputs to reflect changes in practice or new technology. In addition, it will be necessary to ensure that the clinical staff time standards and supply and equipment packages that have been developed through the refinement process are applied appropriately to all services. We are hopeful that the RUC will continue to play a role in this further review and will be discussing this with RUC staff. In addition, we will continue to encourage input from the medical community in general regarding the accuracy of the direct inputs and their pricing.

Comment: There were a few specific concerns raised by commenters regarding the bottom-up methodology. A specialty society representing radiation oncology stated that the bottom-up methodology may be unintentionally compressing higher-cost technology. A health care provider supported the bottom-up approach conceptually, but expressed concerns that aggregate budget neutrality would be more difficult to control using a bottom-up approach than using the top-down. A medical group practice association, as well as a large multi-specialty clinic, had concerns that the RUC recommendations we have accepted for new technical procedures have, because of budget neutrality, eroded the value attributed to cognitive services. MedPAC had concerns about dealing with overvalued services and with the assumptions we use to allocate the cost of equipment to a specific service. For example, MedPAC questioned whether our assumption of 50 percent utilization for all equipment is valid.

Response: We are not sure how the bottom-up methodology would compress higher cost technology, but would be willing to discuss this with the commenter as we develop our next proposal. For budget neutrality, we are not certain that it is harder to control under a bottom-up approach; it would depend on which data source—the aggregate SMS-type data or the PEAC-refined input data—produces the most accurate estimate of direct costs. We understand, in a budget neutral system, the concern about the effect that adding inputs for expensive technology has on cognitive services, but under a bottom-up methodology there would not be the issue of scaling factors exaggerating this effect. We would like very much to discuss the issue raised by MedPAC as we endeavor to improve our PE methodology.

Future Indirect PE Refinement

Comment: Although we did not propose any major change to the indirect PE methodology, other than incorporating the new PE survey data, we did indicate our interest in receiving suggestions on ways to continue to refine the indirect PE calculations. Most commenters focused on the need for us to acquire up-to-date survey information for all specialties so that the PE data for all specialties is as current as possible. Specialty societies representing infectious disease physicians, orthopaedists, remote cardiac services, chest physicians and physical medicine commented that we should extend the deadline to allow specialty societies to conduct supplemental PE surveys. A commenter representing otolaryngologists stated this would not be a preferred option since the high cost involved with conducting surveys would disadvantage smaller specialties.

Other specialty societies representing cataract surgeons, anesthesiologists, emergency medicine and otolaryngology recommended that an unbiased SMS-type survey that cuts across all specialties would be most appropriate for use in the future, instead of having data from different time periods. In arguing for this multi-specialty approach, an emergency medicine association commented that, as MedPAC reports have indicated, only specialty societies who are likely to gain ground have incentive to produce new surveys. The specialty society representing otolaryngology cited the discussion in the Lewin Group report, ''Recommendations Regarding Supplemental Practice Expense Data Submitted for 2006,'' that suggests that the increase in the surveyed PE/HR could indicate a ''secular trend in rising physician PEs,'' and the need for a multi-specialty PE survey. The commenter also suggested that a universal survey could be paid for by using funds reallocated from the oncology demonstration. A specialty society representing spine surgeons commented that all physicians should have the opportunity to submit data relevant to their specialties because it would be unfair to reduce PE reimbursement for providers such as neurosurgeons and orthopedic surgeons without allowing those providers that opportunity to submit accurate data. The society suggested that, as we have established a model for survey data, we could allow societies to survey their membership and submit the results, either directly to CMS or through the RUC. An association representing medical group practices recommended that a comprehensive study be initiated to accurately balance the relativity of overhead costs of practice for each service on a nationwide basis and that this include the costs of information technology (IT) implementation. An emergency medicine commenter recommended including survey questions on uncompensated care.

Response: We agree with all the commenters that, for the PE RVUs to reflect accurately the relative indirect costs for all services, it would be most preferable to have current data for all specialties. However, section 212 of the BBRA required that we establish a process to use data developed by entities and organizations to supplement the data we normally collect in determining the PE component. We established this process and set criteria and a timeline for submission of this data. Although we twice extended the period during which we would accept these supplemental data, we are not proposing to extend this period beyond this year. We believe

that there has been sufficient time for individual specialties that had sufficient member support to do a survey, and that had reason to believe that the results of a survey would be helpful, to submit supplementary PE data to us. Therefore, we agree with the commenters who suggest that a multi-specialty survey done for a uniform time period would be most helpful. We are now planning to work with the AMA and the medical community to develop a strategy for funding and fielding a multi-specialty indirect PE survey that will help ensure that our PE methodology treats all specialties equitably.

Comment: Several commenters offered the following suggestions for revisions to the indirect methodology.

Comments from two associations representing speech language pathologists and audiologists argued that the current method of assigning indirect costs to their services results in a gross underestimation of these costs for both audiology and speech-language pathology services. One association suggested an alternative method of basing indirect costs on the ratio of the refined direct costs to the total costs for all physicians or for otolaryngologists.

A specialty society representing allergy expressed concern that the indirect costs of an allergy practice are not properly accounted for in the current methodology because most either are not assigned work RVUs or have very low work RVUs, but may have high actual indirect costs. The society recommended that we should either establish a mechanism for adjusting the indirect PE when the existing formula yields an inequitable result, or revise the direct costs to include administrative staff time.

A comment from a manufacturer stated that we should not use the ''All Physician'' indirect cost data for IDTFs and recommended using the radiology PE/HR figure for IDTF radiological services and the cardiology PE/HR for IDTF cardiology services, with the exception of the cardiac remote monitoring services which should be paid at current levels, pending the collection of additional data.

A comment from a clinical oncology society recommended that any revision in the methodology for direct costs should be accompanied by a revision in the methodology for allocating indirect costs. The society stated that both the Lewin Group and the Government Accountability Office have found that the current methodology for indirect costs is biased against services that lack a physician work component.

A family physician association questioned why we use physician work, rather than physician time, in our formula for allocating indirect expenses. The commenter stated that there is no evidence that PE would vary with physician intensity and recommended that we use physician time rather than work in the allocation of indirect expenses.

A group representing cardiac services providers recommended that if and when the new methodology is applied to remote cardiac monitoring, indirect costs for these services should be based on a survey of their group and not on the ''All Physician'' average PE/HR, which fails to reflect the actual practice costs incurred. The group also recommended that we allocated indirect costs solely on the basis of direct costs, without regard to physician work.

Response: We thank all the above commenters for their suggestions on improvements to our indirect PE methodology. We will certainly consider all of the above recommendations, as we work with the medical community to develop our next proposal for indirect PE.

Comment: The American College of Surgeons recommends that we convene a multi-stakeholder process to address indirect PE methodological issues so that we can make further changes before final implementation of our new methodology.

Response: As we have mentioned previously, we agree wholeheartedly with the above recommendation. We plan to initiate an open process with the medical community to exchange ideas, answer questions and provide information regarding changes to all aspects of our PE methodology before publication of the next PFS proposed rule. We recognize that in any payment system based on costs, indirect costs are always the most difficult to allocate fairly and accurately. Therefore, we will welcome all suggestions, including those recommended, to improve our indirect PE methodology.

Other Issues

Comment: A group representing community cancer centers requested that we review the PE RVUs for drug administration services as soon as the needed data are available to ensure that they accurately reflect all the costs associated with these services. The National Patient Advocate Foundation agreed because of concern that use of the current indirect PE RVUs will not be sufficient to reimburse oncologists for drug administration costs.

Response: We should have the utilization data needed for the 2006 proposed rule and plan to include the drug administration services in whatever PE methodology is proposed.

Comment: Several commenters recommended that we maintain budget neutrality for PE RVU changes by adjusting the CF proportionately, rather than decreasing only PE RVUs.

Response: Though there could be operational difficulties with adjusting the CF to account for PE budget neutrality, we would like to solicit comments on how best to reflect the budget neutrality for PE.

3. PE Recommendations on CPEP Inputs for CY 2006

Since 1999, the PEAC, an advisory committee of the AMA's RUC, provided us with recommendations for refining the direct PE inputs (clinical staff, supplies, and equipment) for existing CPT codes. The PEAC held its last meeting in March 2004 and the AMA established a new committee, the PERC, to assist the RUC in recommending PE inputs.

With the PERC's assistance, the RUC completed refinement of approximately 200 remaining codes at its meetings held in September 2004 and February 2005. A list of these codes appeared in Addendum C of proposed rule.

We reviewed the RUC-submitted PE recommendations and proposed to adopt nearly all of them. We worked with the AMA staff to correct any typographical errors and to make certain that the recommendations are in line with previously accepted standards.

As stated in the proposed rule, we revised the PE database to reflect these RUC recommendations which can be found on our web site. (See the ''Supplementary Information'' section of this rule for directions on accessing our web site.)

We disagreed with the RUC's recommendation for clinical labor time for CPT code 36522, *Extracorporeal Photopheresis.* In the CY 2005 final rule (69 FR 66236), we assigned, on an interim basis, 223 minutes of total clinical labor for the service period based on the typical treatment time of approximately 4 hours. The RUC, however, recommended 122 minutes total clinical labor time for the service period, which allowed for 90 minutes of nurse ''intra service'' time for the performance of the procedure (the society originally proposed 180 minutes). We believe that 135 minutes is a more appropriate estimation of the clinical staff time actually needed for the intra time, as it more closely approximates the time assigned to the other procedures in this family of codes, including CPT codes 36514, 36515, and 36516. Therefore, we proposed a total

clinical labor time of 167 minutes for the service period. We did not receive specific comments for this revision and are finalizing this change to the clinical labor time. While we have made the change in the PE database, the PE RVUs for 2006 will not reflect the adjustment due to the decision concerning the PE methodology to maintain all PE RVUs at the 2005 level as discussed previously.

The RUC also recommended that no inputs be assigned to several codes because the services were not performed in the office setting. However, our utilization data shows that 4 of these codes (CPT codes 15852, 76975, 78350, and 86585) are currently priced in the office and are performed with sufficient frequency in the office to warrant this. Therefore, we proposed not to accept the RUC recommendations for these services at this time, but requested comments from the relevant specialties as to whether the recommendations should be accepted.

Comment: We received comments from one specialty society disagreeing with the RUC's recommendation for CPT 78350, single photon bone densitometry, as they believe this procedure is being performed in the office. They expressed their intentions to work with CMS as they develop appropriate PE inputs for this procedure in the nonfacility setting. The specialty society also expressed their agreement with the RUC's recommendation to eliminate the nonfacility PE RVUs for 76975 because virtually all of these exams are performed in the facility setting. In addition, a national organization representing medical directors of respiratory care, supported the retention of nonfacility PE RVUs for CPT 86585, TB tine test, because they believe it to be a legitimate office-based procedure. We did not receive comments on the appropriateness of nonfacility RVUs for CPT 15852.

Response: We will maintain the nonfacility setting PE RVUs for 78350 and look forward to working with the specialty society in their initiative to develop inputs for this procedure. We will remove the PE inputs for the nonfacility setting for CPT codes 76976 and 15852, although for the 2006 PFS these codes will reflect the 2005 PE RVU amounts. CPT 86585 has been deleted from CPT 2006 and will not appear on Addendum B.

4. Payment for Splint and Cast Supplies

In the Physician Fee Schedule (CY 2000); Payment Policies and Relative Value Unit Adjustment final rule, published November 2, 1999 (64 FR 59379) and the Physician Fee Schedule (CY 2002); Payment Policies and Relative Value Units Five-Year Review and Adjustments final rule, published November 1, 2000 (66 FR 55245), we removed cast and splint supplies from the PE database for the CPT codes for fracture management and cast/strapping application procedures. Because casting supplies could be separately billed using Healthcare Common Procedure Coding System (HCPCS) codes that were established for payment of these supplies under section 1861(s)(5) of the Act, we did not want to make duplicate payment under the PFS for these items.

However, in limiting payment of these supplies to the HCPCS codes Q4001 through Q4051, we unintentionally prohibited remuneration for these supplies when they are not used for reduction of a fracture or dislocation, but rather, are provided (and covered) as incident to a physician's service under section 1861(s)(2)(A) of the Act.

Because these casting supplies are covered in sections 1861(s)(5) or 1861(s)(2)(A) of the Act, we proposed to eliminate the separate HCPCS codes for these casting supplies and to again include these supplies in the PE database. This would allow for payment for these supplies whether based on section 1861(s)(5) or 1861(s)(2)(A) of the Act, while ensuring that no duplicate payments are made. In addition, by bundling the cost of the cast and splint supplies into the PE component of the applicable procedure codes under the PFS, physicians would no longer need to bill Q-codes in addition to the procedure codes to be paid for these materials.

Because these supplies were removed from the PE database prior to the refinement of these services by the PEAC, we proposed to add back the original CPEP supply data for casts and splints to each applicable CPT code and we requested that the relevant medical societies review the ''Direct Practice Expense Inputs'' on our web site and provide us with feedback regarding the appropriateness of the type and amount of casting and splinting supplies. We also requested specific information about the amount of casting supplies needed for the 10-day and 90-day global procedures, because these supplies may not be required at each follow-up visit; therefore, the number of follow-up visits may not reflect the typical number of cast changes required for each service.

We reincorporated the following cast and splint supplies as direct inputs: fiberglass roll, 3 inch and 4 inch; cast padding, 4 inch; webril (now designated as cast padding, 3 inch); cast shoe; stockingnet/stockinette, 4 inch and 6 inch; dome paste bandage; cast sole; elastoplast roll; fiberglass splint; ace wrap, 6 inch; and kerlix (now designated as bandage, kerlix, sterile, 4.5 inch) and malleable arch bars. The cast and splint supplies were added, where applicable, to the following CPT codes: 23500 through 23680, 24500 through 24685, 25500 through 25695, 26600 through 26785, 27500 through 27566, 27750 through 27848, 28400 through 28675, and 29000 through 29750.

Because we proposed to pay for splint and cast through the PE component of the PFS, we would no longer make separate payment for these items using the HCPCS Q-codes.

Comment: We received a comment on behalf of the American Osteopathic Academy of Orthopedics (AOAO) that provided specific information for the type and number of casts needed for the 10 or 90-day global period for each code in the relevant fracture management series. The AOAO also noted the type and amount of casting supplies, including stockinette, cast padding, fiberglass and post-op cast shoe, as appropriate.

We also received a comment from the RUC expressing their appreciation for the proposal to make coding and billing for fracture management and casting/strapping supplies easier by reducing the number of codes for physicians to submit. In addition, the RUC expressed interest in reviewing the data submitted in response to our proposal so that the resulting casts and strapping PE inputs can ''enjoy the same level of scrutiny and cross-specialty refinement that all of the other PE inputs have''.

Other specialty societies supported our proposal to include casting material in the fracture care codes and the elimination of the Q codes. However, some of these societies expressed concerns about bundling all of the necessary casting/strapping supplies for the global period into the fracture management codes. These commenters related that only the initial cast/strapping supplies should be bundled into the relevant fracture care code series and that physicians should be able to continue to submit separate claims for the CPT codes for the application of casts and strapping procedures during the global period.

Many commenters, primarily from orthopedic practices, expressed concern about the proposal, but misunderstood that this proposal was separate from the anticipated negative update for 2006 based on the SGR methodology.

Response: We thank AOAO for submitting the information we requested in the proposed rule. The society submitted a clear,

comprehensive and beautifully prepared spreadsheet detailing each CPT code in the various fracture management series. We commend them on their efforts to submit such a thorough and meticulous document in response to our proposed rule request.

For the 2006 fee schedule, based on the decision concerning PE methodology to maintain all PE RVUs at the 2005 level previously discussed, we have removed the CPEP inputs for casts and splints from the PE database and CMS will retain use of the Q-code fee schedule as done in the past. In addition, we will use the interim time period before the notice of proposed rulemaking for the 2007 fee schedule to work with the affected specialties and the RUC to clarify issues related to Medicare payment policy and establish more appropriate amounts of casting/strapping materials for the relevant series of fracture management codes and the casts and strapping application codes. Due to the temporary status and intended limited use of the Q-code fee schedule, it is our intention to resolve these important payment issues in the near future. A detailed discussion of the SGR and the update for 2006 is found later in this final rule with comment.

5. Miscellaneous PE Issues

In this section, we discuss our specific proposals related to PE inputs.

a. Supply Items for CPT Code 95015

We proposed to change the supply inputs for CPT code 95015, *intracutaneous (intradermal) tests, sequential and incremental, with drugs, biologicals or venoms, immediate type reaction, specify number of tests,* based on comments received from the JCAAI. JCAAI reported that ''venom'' is the most typical test substance used when performing this service and that ''antigen'', currently listed in the PE database, is never used. They also suggested that the appropriate venom quantity should be 0.3 ml (instead of the 0.1 ml listed for CY 2005) because of the necessity to use all 5 venoms (honey bee, yellow jacket, yellow hornet, white face hornet and wasp) to perform this sensitivity testing; that is, 1 ml of each venom type for a total of 5 ml of venom. The diluted venoms are sequentially administered until sensitivity is shown, beginning with the lowest concentration of venom and subsequently administering increasing concentrations of each venom. We accepted the specialty's argument and proposed to change the test substance in CPT code 95015 to venom, at $10.70 (from single antigen, at $5.18) and the quantity to 0.3 ml (from 0.1 ml).

Comment: JCAAI expressed their appreciation for our proposal to change the supply item input for CPT 95015 from 0.1 ml antigen to .3 ml of venom.

Response: The appropriate changes have been made to our PE database. However, as discussed above, because we are making only limited, necessary changes to PE RVUs for the 2006 PFS, the PE RVUs for this code will continue to reflect the 2005 PE RVU amounts.

b. Flow Cytometry Services

In the CY 2005 final rule (69 FR 66236), we solicited comments on the interim RVUs and PE inputs for new and revised codes, including flow cytometry services. Based on comments received and additional discussions with representatives from the society representing independent laboratories, we proposed to revise the PE inputs for the flow cytometry CPT codes 88184 and 88185.

Based on information from the specialty society, we proposed to change the direct inputs used for PE as follows:

- Clinical Labor: Change the staff type in the service (intra) period in both CPT codes 88184 and 88185 to cytotechnologist, at $0.45 per minute (currently lab technician, at $0.33 per minute).
- Supplies: Change the antibody cost for both CPT codes 88184 and 88185 to $8.50 (from $3.544).
- Equipment: Add a computer, printer, slide strainer, biohazard hood, and FACS wash assistant to CPT code 88184. Add a computer and printer to the equipment for CPT code 88185.

Comment: We received comments from several organizations including those representing professional services in clinical laboratories, manufacturers, clinical laboratories, and clinical pathologists. These commenters all supported our proposal to revise the PE inputs outlined above for the flow cytometry CPT codes 88184 and 88185.

Response: We appreciate the support extended to us by these national organizations in regards to the revision of direct inputs for the CPT codes for flow cytometry. The PE changes have been made, as indicated above, to the database. However, because we are making only limited, necessary changes to PE RVUs for the 2006 PFS, the PE RVUs for these codes will continue to reflect the 2005 PE RVU amounts.

c. Low Osmolar Contrast Media (LOCM) and High Osmolar Contrast Media (HOCM)

HOCM and LOCM are used to enhance images produced by various types of diagnostic radiological procedures. In the CY 2005 final rule (69 FR 66356), we eliminated the criteria for the payment of LOCM that had been included at § 414.38. Effective April 1, 2005, providers can receive separate payment for LOCM when used with procedures requiring contrast media through the use of separate Q-codes. Payment for HOCM is currently included as part of the PE component under the PFS. We proposed, effective January 1, 2006, to no longer include payment for HOCM under the PFS and to establish Q-codes for the separate payment of HOCM.

As noted in the proposed rule we reviewed the PE database and proposed to remove the following two supply items which we have identified as HOCM from the PE database:

- Conray inj. iothalamate 43 percent(supply item #SH026, deleted from 64 procedures).
- Diatrizoate sodium 50 percent (supply item #SH0238, deleted from 74 procedures).

We also identified 5 CPT codes (specifically CPT codes 42550, 70370, 93508, 93510 and 93526) that included omnipaque as a supply item, and proposed to remove this supply item from these 5 CPT codes since omnipaque is actually a type of LOCM.

Comment: We received several comments from organizations representing radiology physicians and manufacturers on our proposal to delete HOCM from the PE database. The commenters supported our proposal for separate payment for both HOCM and LOCM to ensure beneficiaries access to all the various types of medical imagining contrast media. The commenter representing the manufacturers requested that we notify carriers that separate payment for LOCM and HOCM is available.

Response: We thank the organizations for their comments in support of our proposal which would permit separate payment for HOCM in 2006. We have removed HOCM from the direct inputs in the PE database and also deleted LOCM from the 5 procedures as noted above. However, because we are not implementing the bottom-up methodology which utilizes the direct inputs to determine the PE RVUs, these imaging codes will again be valued in the NPWP where the PE RVUs are established using an appropriate crosswalked charge-based RVU containing HOCM as an inherent supply cost. We will delay separate payment for HOCM until such time the direct inputs are used to determine PE RVUs. For 2006, the PE RVUs will be retained at the 2005 level. We remind the commenters that the average sales price

(ASP) quarterly values are published on our Web site at the following address: *http://www.cms.hhs.gov/providers/drugs/asp.asp.*

d. Imaging Rooms

We include standardized ''rooms'' for certain services in our PE equipment database, rather than listing each item separately. We received pricing information from the ACR for the following rooms that are included in the database. We accepted most of the proposed items that met the $500 threshold for equipment and proposed to include the items in each specific room, as follows:

- *Basic Radiology Room:* $127,750 (x-ray machine @ $125,550 and camera @ $2,200). The recommended viewbox was not included because most codes assigned this room have also been assigned an alternator (automated film viewer) or a 4-panel viewbox.
- *Radiographic-Flouroscopic Room:* $367,664 (Radiographic machine @ $365,464 and camera @ $2,200). The recommended viewbox was not included because most codes assigned this room have also been assigned an alternator (automated film viewer) or a 4-panel viewbox.
- *Mammography Room:* $168,214 (mammography unit @ $124,900; reporting system @ $16,690; mammography phantom @ $674; densitometer @ $3,660; sensitometer @ $2,750; desktop PC for monitoring @ $1,840; and processor @ $17,700. Separately listed equipment items (densitometer, mammography reporting system, sensitometer, mammography phantom, desktop computer, and the film processor) that duplicated items included in the mammography room were removed from the codes assigned the room, eliminating the reporting system, sensitometer and phantom from the PE database.
- *Computed tomography (CT) Room:* $1,284,000 (16-slice CT scanner with power injector and monitoring system)
- *Magnetic Resonance Imaging (MRI) Room:* $1,605,000 (1.5T MR scanner with power injector and monitoring system)

Comment: We received comments from one specialty society requesting that we add 4 cassettes to the composition and cost of the mammography room although each cassette does not meet the $500 equipment threshold. Another commenter representing a large radiology group practice agreed that our cost allowance for the mammography room was appropriate for the standard analog mammography room. However, this commenter asked us to develop a separately identified cost for a digital mammography room, costing approximately 3 to 4 times as much as the analog room, citing this digital system provides better diagnostic services.

Response: We appreciate the comments regarding the cost and composition of the mammography room. We are sympathetic to the commenter's request for the creation of a separate digital mammography room. However, the direct PE inputs for labor, supplies and equipment that are included in physicians' services reflect the costs involved in the typical procedure or service provided in the nonfacility setting. We believe that the mammography room we proposed represents the equipment used to provide the typical mammography service and was based on information provided by the specialty society.

We disagree with the specialty society in regards to adding the cost of the 4 cassettes to the room's price. The threshold for the inclusion of equipment for PE purposes remains at $500. For this reason, we will finalize the value of the mammography room as proposed, at $168,214.

In addition we will finalize the proposed values for all of the above imaging rooms in this final rule with comment. However, because we are adopting only limited, necessary changes to PE RVUs for CY 2006, and will continue to utilize the NPWP to value these services, the RVUs will remain the same as those for 2005.

e. Equipment Pricing for Select Services and Procedures From the CY 2005 Final Rule (69 FR 66236)

In the August 8, 2005 proposed rule, we presented information on pricing of equipment for select services and procedures based on specialty information and stated we would be accepting the prices. The specific equipment was as follows:

- Equipment pricing for certain radiology services received from the ACR were presented in table 15 of the proposed rule.
- Equipment pricing on the Ultrasound color Doppler transducers and vaginal probe received from the American College of Obstetrics and Gynecology was presented.
- For CPT 36522, extracorporeal photopheresis, we discussed equipment pricing information specific to this procedure.
- Pricing of EMG botox machine used in CPT code 92265 as presented by the American Academy of Ophthalmology.

No comments were received on these items, therefore, the prices discussed in the proposed rule will be used in the PE database. However, we will continue to use the 2005 PE RVUs for each of these codes for CY 2006.

f. Supply Item for In Situ Hybridization Codes (CPT 88365, 88367, and 88368)

As discussed in the August 8, 2005 proposed rule, we received comments in response to the CY 2005 final rule from the College of American Pathologists regarding the number of DNA probes assigned to the in situ hybridization codes, CPT codes 88365, 88367, and 88368. Currently, CPT codes 88365 and 88368 have 1.5 probes assigned, while CPT code 88367 has only 0.75 of a probe assigned. The College of American Pathologists requested that we assign 1.5 probes to CPT code 88367, and provided justification for this request. We accepted the College of American Pathologists' rationale and proposed to change the probe quantity for CPT code 88367 to 1.5.

Comment: A society representing clinical pathologists supports the proposed change to the probe quantity for CPT 88367.

Response: We have entered the number of probes, at 1.5, to our PE database. This change will not be expressed in the 2006 PE RVUs because as discussed above, we will retain the 2005 PE RVUs.

g. Supply Item for Percutaneous Vertebroplasty Procedures (CPT Codes 22520 and 22525)

The Society for Interventional Radiology (SIR) provided us with documentation for the price of the vertebroplasty kit used in CPT codes 22520 and 22525. We proposed to accept a new price of $696 for this supply, currently listed as $660.50, a placeholder price from the CY 2005 final rule.

Comment: Commenters supported the proposed $696 cost estimate for the vertebroplasty kit.

Response: We are finalizing our proposal to value the vertebroplasty kit price at $696 in the supply database, although, as discussed previously, this will not be reflected in the 2006 PE RVUs because we will retain the 2005 PE RVUs.

h. Clinical Labor for G-codes Related to Home Health and Hospice Physician Supervision, Certification and Recertification

As discussed in the August 8, 2005 PFS proposed rule, 4 G-codes related to home health and hospice physician supervision, certification and

recertification, G0179, 180, 181, and 182, are incorrectly valued for clinical labor. These codes are cross-walked from CPT codes 99375 and 99378, which underwent PEAC refinement in January 2003 for the 2004 fee schedule. However, we did not apply the new refinements to these specific G-codes. This was an oversight on our part and we proposed to revise the PE database to reflect the new values in the 2006 physician fee schedule.

Comment: Commenters, including those representing the specialty societies for home care physicians and internists, expressed concern about the decrease in PE RVUs for the G-codes for hospice and home health supervision and care plan oversight services. One commenter requested that we elaborate on the sequence of events that lead to this decrease.

Response: We appreciate the concern expressed by the commenters and are providing additional information outlining the reason for this change. For the 2001 PFS, these G-codes were created in order to provide payment for these specific services. Changes made to the CPT codes (CPT codes 99375 and 99378) for 2001 did not enable us to recognize the CPT codes for Medicare payment purposes. Therefore, the PE inputs that had been applied to these CPT codes were cross-walked and used to establish the PE RVUS for the G codes that we established for these services. Subsequent to this, the CPT codes underwent refinement by the PEAC at its January 2003 meeting where a majority of the other E/M services were refined. CMS accepted these PE recommendations from the PEAC that included only a total of 36 minutes for clinical labor. The PEAC recommendations did not include supplies and equipment because they did not believe these were utilized in the typical services represented by these codes. These PE inputs were intended to be crosswalked to the G-codes for 2004, however, due to an oversight, this did not occur. We apologize to the specialties that this refinement was not done in a timely manner. Thus, we are finalizing the direct inputs for these G-codes in this rule and have changed the PE database accordingly. However in 2006, the PE RVUs for these 4 G-codes will remain at the 2005 level, as explained above.

i. Programmers for Implantable Neurostimulators and Intrathecal Drug Infusion Pumps

Subsequent to the CY 2005 final rule, we received comments from a manufacturer of programmers for implantable neurostimulators and intrathecal drug infusion pumps. The commenter indicated that the equipment costs for these programmers are not a direct expense for the physicians performing the programming of these devices and that the manufacturer furnishes these devices without cost because the programming device is considered a ''necessary, ancillary item to the neurostimulator and drug pump and can only be used to program these devices.'' Therefore, we proposed to remove the 2 programmers from the PE database: EQ208 for medication pump from 2 codes (CPT 62367 and 62368) and EQ209 for the neurostimulator from 8 codes (CPT 95970–97979). We also requested comments from the specialty societies performing these services as to whether this reflects typical practice.

Comment: Several commenters disagreed with this proposal indicating that not all programmers are provided without cost. Specifically, for the one manufacturer, the practice of providing physicians with these programmers free of charge is just a recent occurrence. In addition, one commenter informed us that there are other PE items that are not accounted for, including a printer, for 62367 and 62368. The RUC commented that several specialty societies conducted an email-based survey finding that the majority of the respondents reported paying for these programmers. The RUC asked us to reconsider our decision to delete the programmers from the PE direct inputs because it was based solely on the recommendation of one manufacturer.

Response: We are sympathetic to the commenters' concerns about the programmers used by pain medicine physicians. We have carefully reviewed our decision to delete the programmers from the PE database in light of the comments we received. Therefore, based on the uncertainty as to which brand product is typical, the survey results presented to us by the RUC, and the life, 7 years, of each programmer, we have determined that we will retain these programmers in the database. In addition, we have added ''with printer'' to the description of EQ208 to match that of EQ209 in order to assuage the commenter's concern that the price listed in the database, $1975, correctly reflects the cost of both the programmer and the printer. Because the PE RVUs for 2005 contained the price for these programmers, the PE RVUs for 2006 will continue to reflect their costs.

j. Pricing of New Supply and Equipment Items

As part of the CY 2005 final rule process, we reviewed and updated the prices for equipment items in our PE database and assigned a unique identifier to each equipment item with the first 2 elements corresponding to one of 7 categories. It was brought to our attention that we assigned the same category identifier (ELXXX) for both ''lanes/rooms'' as well as ''laboratory equipment''. To correct this, we proposed assigning laboratory equipment items the new category identifier ''EPXXX'', but the specific numbers associated with each item would remain the same. In addition, supply items were reviewed and updated in the rulemaking process for the 2004 PFS. During subsequent meetings of both the PEAC (now referred to as the PERC) and the RUC, supply and equipment items were added that were not included in the pricing updates. In the proposed rule we included 2 tables (Table 16: Proposed Practice Expense Supply Items and Table 17: Proposed Practice Expense Equipment Items) that listed the additional supply and equipment items for 2006 and the proposed associated prices that we would use in the PE calculation. The listing of new supplies and equipment in the proposed rule does not guarantee that the price listed for each item has been accepted. Rather, the new supply and equipment tables are to make specialties aware of the descriptors and assigned supply or equipment codes that can be used in future proposals to the RUC and HCPAC. As discussed below, the addition of an item to the tables for new supplies or equipment does not preclude the inclusion of the same item on the tables that require more detailed information and documentation from the specialty organization.

k. Supply and Equipment Items Needing Specialty Input

We also identified certain supply and equipment items for which we were unable to verify the pricing information, reflected in Table 18: Supply Items Needing Specialty Input for Pricing and Table 19: Equipment Items Needing Specialty Input for Pricing of the proposed rule. We stated that the items listed in these tables represent the outstanding items from last year and new items added from the RUC recommendations. Therefore, we requested that commenters, particularly specialty organizations, provide pricing information on items in these tables along with documentation to support the recommended price.

Tables 14 and 15 reflect the comments and documentation we received for each item. Specialty societies are asked to review these supplies and equipment, as

appropriate, to assure that the item status is accurate and forward any necessary documentation. We would also like to reinforce the types of documents that meet the acceptable category. The following list includes examples of acceptable documentation:

- Photocopy or actual vendor catalog listing, indicating price, accessories or components (if applicable), available quantity, company name, brand name, and catalog date. Scanned versions, if readable, can also be emailed.
- Photocopy of web page with specific supply or equipment including the necessary information listed in above bullet.
- Photocopy of invoice indicating the price paid for specific supply or equipment, as well as the specific contents of kit, pack or tray for supplies and component or accessory parts for the equipment item.
- Letter, FAX or e-mail from manufacturer, vendor or distributor noting the ASP of the supply or equipment. The description of the item must list all contents, accessories or component parts that are included in the price.

The following information is not considered acceptable documentation, including:

- Web site addresses.
- Vendor, manufacturer, or distributor phone number and address.
- Approximated values.

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TABLE 14: Supply Items Needing Specialty Input for Pricing

Code	2005/6 Description	Unit	Unit Price	Primary associated specialties	Associated *CPT code(s)	Item Status: refer to note(s)	Commenter response and CMS action	2006 Item Status refer to note(s)
SK105	blood pressure recording form, average	Item	0.31	Cardiology	93784, 93786, 93788	A	Specialty to submit asap, per comment.	A, E
SJ072	Brush, disposable applicator	Item		Dermatology	17360	A	Specialty to submit asap, per comment.	A, B
SK102	Communication book/treatment notebook	Item		Audiology, ENT	92510	A	No comments received	A, B
SK103	Cork sheet, 1 cm x 1 cm	Item		Pathology	88355	A	Documentation provided. Accept price at .02/ 1cm x 1cm	C
SJ073	DMV remover	Item		Optometry, Opthalmology	92310 - 92317	A	Specialty provided price, box of 10, $19.95 w/o documentation. Accept $1.995.	A, B
SD217	Diaphragm fitting set	Item		Ob-gyn	57170	A	Submitted price of $75 Accept on interim basis.	A, B
SD054	Electrode, EEG, tin cup (12 pack uou)	Item		Neurology	95812-13, 95816, 95819, 95822, 95950, 95954, 95956	A	Submitted price of $18 for 12 pack Accept on interim basis.	A, B
SC088	Fistula set, dialysis, 17g	Item		Dermatology	36522	A	Specialty to submit asap, per comment.	A, B
SK104	Foil, aluminum, 10 cm x 10 cm	Item		Pathology	88355	A	Documentation provided. Accept price at .02/1cm x 1cm.	C

Code	2005/6 Description	Unit	Unit Price	Primary associated specialties	Associated *CPT code(s)	Item Status: refer to note(s)	Commenter response and CMS action	2006 Item Status refer to note(s)
SL193	Glycolic acid, 20 - 50%	ml		Dermatology	17360	A	Specialty to submit asap, per comment.	A, B
SA090	Kit, moulage (implantech)	Item	75.00	Plastic Surgery	19396	A	Submitted price by FAX. Accept $75	C
SJ074	Lens cleaner	oz		Optometry, Opthalmology	92313, 92341, 92342	A	Submitted price of $0.69 per oz. w/o documentation. Accept $0.69	A, B
SL199	Lithium carbonate, saturated	ml		Pathology	88355, 88356	A	Documentation provided. Accept price at $0.01 per ml	C
SF044	Micro air burr	Item		Podiatry, Orthopedics	28740, 28750, 28755, 28760	A	No comments received.	A, B
SJ076	Nose pads	Item		Optometry	92370	A	Submitted 3 prices w/o documentation. Will use price for box of 25 at $16.90. Accept $.676	A, B
SG092	Packing, gauze, plain, 1 in (5yd uou)	Item		Ob-Gyn	57180	A	Submitted 2 prices. Will use average $6.17	A, B
SH087	Pentagastrin	ml		Gastroenterology	91052	A	No longer available, per comment.	D
SD140	pressure bag	item	8.925	Cardiology	93501, 93508, 93510, 93526	A	Specialty to submit asap, per comment.	A, E

Code	2005/6 Description	Unit	Unit Price	Primary associated specialties	Associated *CPT code(s)	Item Status: refer to note(s)	Commenter response and CMS action	2006 Item Status refer to note(s)
SL119	Sealant spray	oz		Radiation Oncology	77333	A	No comments received.	A, B
SL200	Sodium bicarbonate spray, 8 oz	Item		Dermatology	17360	A	Specialty to submit asap, per comment.	A, B
SL202	Tissue conditioner, coesoft	Item		Maxillofacial Surgery ENT	42280	A	Submitted price of $8.54 uou. Price accepted.	C
SA091	Tray, scoop, fast track system	tray	750.00	ENT	31730	A	Inadequate documentation received. Need tray contents detailed.	A, E
SD213	tubing, sterile, non-vented (fluid administration)	item	1.99	Cardiology	93501, 93508, 93510, 93526	A	Specialty to submit asap, per comment.	A, E

*CPT codes and descriptions only are copyright 2005 AMA. All Rights Reserved. Applicable FARS/DFARS apply.
Note A: Additional documentation required. Need detailed description (including kit contents), source, and current pricing information (including pricing per specified unit of measure in database). Accept copies of catalog pages or hard copy from specific webpages. Phone numbers or addresses of manufacturer, vendors or distributors are not acceptable documentation.
Note B: No/Insufficient documentation received. Accepted, modified, or current price retained in database, on an interim basis. Forward documentation promptly.
Note C: Submitted price accepted.
Note D. Deleted per comment
Note E: 2005/2006 price retained on an interm basis. Forward documentation promptly.

TABLE 15: Equipment Items Needing Specialty Input for Pricing and Proposed Deletions

Code	2005/6 Description	2005 Price	Primary specialties associated with item	*CPT code(s) associated with item	Prior status of item: refer to note(s)	Commenter response and CMS Action	2006 Item Status refer to note(s)
EQ269	Ambulatory blood pressure monitor	3,000	Cardiology	93784, 93786, 93788	A	No comments received.	A and F

Code	2005/6 Description	2005 Price	Primary specialties associated with item	*CPT code(s) associated with item	Prior status of item: refer to note(s)	Commenter response and CMS Action	2006 Item Status refer to note(s)
EQ089	stimulator, cortical bipolar-biphasic, w-output cable, stim/record switching unit & ground +stimulating electrodes		Neurosurgery, neurology	95961, 95962	A	Specialty submitted price accepted except $20 for mounting brackets. EQ089 descriptor changed.	G and J
EQ091	cryo system, w-nerve stimulator, console, digital temp indicator & timer (PainBlocker)		Anesthesia	64620	A and C	Commenter provides price of $25,480. Modified price accepted at $14,995. EQ184 may be removed if duplicated. EQ091 descriptor changed.	J and L
ER025	densitometry unit, whole body, SPA	22,500	Radiology	78350	A and C	Commenters note ER025 no longer built. Price reduced $5000 - compared to decrease in repricing ER026. Accepted price $17,500.	L
EQ100	dialysis access flow monitor	10,000	Nephrology	90940	A	No comments received.	A, E and F
EQ101	diathermy, microwave		IM, Physical therapy, GP	97020	A and C	97020 deleted in CPT 2006. EQ101 is removed from database.	H and I
EQ008	ECG signal averaging system	8,250	Cardiology, IM	93278	A	No comments received.	A , E and F
EQ112	electromagnetic therapy machine	25,000	Physical therapy	G0329	A	No comments received.	A , E and F
EQ122	fetal monitor software	35,000	ob-gyn, radiology	76818, 76819	A	Requested deletion from both codes, 76818 and 76819, and database.	H and I
ER029	film alternator (motorized film viewbox)	27,500	Radiology	329 codes	A and B	No comments received.	A , E and F
EQ124	stimulator, constant current, w-stimulating and grounding electrodes (Grass Telefactor)	950	Neurology, NP	95923	A	Price accepted per comment. EQ124 descriptor changed.	G and J
EQ131	Hyperbaric chamber	125,000	FP, IM, EM	99183	A	No acceptable documentation forwarded.	A, E, and F
ER036	hyperthermia system, ultrasound, intracavitary	250,000	radiation oncology	77620	A	Specialty to forward information asap, per comment.	A , E and F
	Light assembly, photopheresis		Dermatology	36522	A	Specialty to forward information asap per comment.	A

Code	2005/6 Description	2005 Price	Primary specialties associated with item	*CPT code(s) associated with item	Prior status of item: refer to note(s)	Commenter response and CMS Action	2006 Item Status refer to note(s)
ER045	orthovoltage radiotherapy system	140,000	radiation oncology	77401	A	No comments received.	A, E and F
ER008	OSHA ventilated hood	5,000	radiation oncology	77334	A and B	No comments received.	A, E and F
	plasma pheresis machine w/UV light source	37,900	radiology, dermatology	36481, G0341	A	No comments received.	A, E and F
EQ208	Programmer, for implanted medication pump (spine) (w-printer)	1,975	anesthesiology, physical medicine	62367, 62368	D	Submitted comments supporting most physicians pay for programmers. Price retained. EQ208 descriptor changed.	G and J
EQ209	Programmer, neurostimulator (w-printer)	1,975	neurology, neuro surgery, anesthesiology	95970, 95971, 95972, 95973, 95974, 95975, 95978, 95979	D	Submitted comments supporting payment for equipment by physicians. Price retained.	G
EQ212	pulse oxymetry recording software (prolonged monitoring)	3,660	Pulmonary disease, IM	94762	A	Invoice submitted with price of $3,890. Price accepted at $3,890.	G
EP055	Slide Stainer	9,291	Pathology	88184	A	Specialty commented that EP037 should be used in place of EP055. EP055 was deleted from PE database. EP037 entered in database for CPT 88184.	K and G
EQ271	Radiuscope	1,595	ophthalmology, optometry	92310 - 92317	A	Commenters provided distributor phone and address information. Price accepted, on interim basis. More documentation needed.	A and G
EQ220	remote monitoring service (neuro-diagnostics)	9,500	Neurology	95955	A	Commenter notes no longer used for CPT 95955. Service requires new technology of reader software (CASCADE) and ED021.	H and K

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Code	2005/6 Description	2005 Price	Primary specialties associated with item	*CPT code(s) associated with item	Prior status of item: refer to note(s)	Commenter response and CMS Action	2006 Item Status refer to note(s)
EQ221	review master	23,500	pulmonary disease, neurology	95805, 95807-11, 95816, 95822, 95955-56	A	Unacceptble documentation received.	A, E and F
EF022	table, cystoscopy		Urology	52204-24, 52265-75, 52310-17, 52327-32	A	Commenter requests deletion of EF022 and replacement with power table, EF 031. EF031 was added to 12 codes and EF031 was deleted from database.	K and I
EQ253	ultrasound, echocardiography digital acquisition (Novo Microsonics, TomTec)	29,900	ob-gyn, cardiology, pediatrics	76825-28, 93303-12, 93314, 93320, 93325, 93350	A	Provided comments to delete from CPT 76825-76828.	H
EQ261	vacuum cart		anesthesia	64620	A and C	EQ261 appears as an artifact on PEAC spreadsheet from August 2001.	H and I
EP053	Wash assistant, FACS	38,000	pathology	88184	A	Specialty submitted price and documentation. Price accepted at $38,000	G

A. Additional documentation is required. Need detailed description (including system components as specified), source, and current pricing information, such as copies of catalog pages, hard copy from specific webpages, or invoices. Phone numbers or addresses of manufacturer, vendors or distributors are not acceptable documentation.

B. Proposed deletion as indirect expense.

C. Item may no longer be available.

D. Proposed deletion as supplied to physicians at no cost.

E. No/Insufficient documentation. Retained price in database, on an interim basis. Forward documentation promptly.

F. 2005/2006 price retained, on an interim basis. Forward acceptable documentation promptly as applicable.

G. Submitted price or rationale accepted. Appropriate changes made to database.

H. Deleted per comment, CPT 2006, or by CMS staff analysis.

I. Item is deleted from the practice expense database.

J. Item description changed in practice expense database.

K. Replacement equipment added per specialty. Where new, appears on "new equipment table" for 2006.

L. Modified price accepted. Specialty consultation needed, where appropriate, to resolve duplication of equipment and/or documented use of accessories.

l. Additional PE Issues Raised by Commenters

Comment: We received a comment from an equipment distributor and multiple comments from physicians asking us to add more clinical labor, supplies and equipment to CPT codes 78481 and 78483 for cardiac blood pool imaging using the first pass technique. The commenters emphasized that the labor costs are understated, and that additional supplies and equipment are necessary to perform these services. In particular, the commenters requested we add a nuclear medicine gamma camera to the equipment inputs or cross-walk the equipment listed for CPT 78465. The distributor presented supply and equipment tables for both codes, using direct PE inputs currently listed in the PE database, most of these are found in the PE for CPT 78465.

Response: The direct inputs for these ''First Pass'' services were presented by the specialty society to the PEAC at its January 2004 meeting. The RUC forwarded the PEAC's recommendations to CMS for consideration during the rulemaking process for the 2004 fee schedule at which time these recommendations were accepted. We do not believe that we are in a position to make the type of changes to the PE inputs for these 2 codes that the commenters have requested. We recommend that the commenters and the specialty society whose members perform these procedures, work together so that necessary changes can be considered through the usual RUC process.

Comment: We received comments from a specialty society and a manufacturer asking us to replace a supply item, a Tesio type dual catheter, with the Lifesite system in CPT 36566—a procedure described as the insertion of tunneled catheter with subcutaneous port(s). The specialty society explained that when the RUC valued this service in 2003, the incorrect catheter was included with their PE recommendations. The manufacturer asks for our assistance in correcting a ''clerical error'' in our database. The commenters explain that CPT codes 36565 and CPT 36566 are nearly identical in procedure, although CPT 36566 requires the insertion of ''subcutaneous port(s)'' and that the Tesio-type catheter, priced at $355, is currently listed for both of these procedures. The Lifesite system, containing a subcutaneous port, is priced at $1750. Both commenters noted that 2 Lifesite systems are necessary to perform this procedure instead of one for a total supply cost of $3500.

Response: We appreciate the commenters concerns about the specific supplies they believe are needed to perform this service. The work and PE values for CPT 36566 were forwarded by the RUC and accepted in our final rule, for the 2004 fee schedule. We believe that the RUC is the appropriate avenue to address correction of inputs to the PE database, particularly due to the expensive nature of this replacement, and are not revising the PE database to reflect this price change.

Comment: A specialty society commented that it believes the nonfacility PE RVUs were mistakenly deleted from CPT codes 59812, 59840, and 59841. The specialty also requested that nonfacility PE RVUs be added for CPT 58558.

Response: We have reviewed the specialty's request regarding nonfacility PE RVUs for the 4 codes noted above. The ''NA'' indicator for PE RVUs in the nonfacility setting is listed incorrectly for CPT codes 59840 and 59841 in Addendum B of our proposed rule. Both of these CPT codes should have PE RVUs listed in the nonfacility setting. The specialty society is mistaken, however, regarding the appropriateness of nonfacility PE RVUs for CPT 59812 and 58558. These codes have both undergone refinement by the PEAC at least once and the recommendations forwarded by the RUC clearly indicated that these procedures were not valued in the nonfacilty setting. We have changed our database, as appropriate, to reflect the changes for CPT 59840 and 59812.

Comment: We received comments from a specialty organization citing that the total RVUs for CPT 19298 are too low in comparison to those for CPT 19296—both new CPT codes for CY 2005. The specialty believes this difference is likely due to the supply PE inputs necessary to perform each procedure. The specialty states that the catheter supply expenses should be similar between the 2 services, yet the nonfacility PE RVUs for CPT 19298 (39.56) are significantly lower than those listed for CPT 19296 (117.96). The specialty stated that while the average number of catheters used for CPT 19298 is 25, ranging from 15–30, this cost should be comparable to the catheter required for CPT 19296. Finally, the specialty requests that we crosswalk the total RVUs for the nonfacility setting from CPT 19296 to CPT 19298 for 2006 while they gather detailed information to present to us.

Response: We have researched the specialty's concern about the supply cost differences between the 2 new CPT codes for 2005. Whereas the specialty contends that the catheter expenses are similar, or only somewhat greater for CPT 19296, we found that the differences between these 2 supply costs is significant. The mammosite tray, containing the catheter used for CPT 19296, is priced at $2,550 while the button-end implant catheters used for CPT 19298 are priced at $18.50 each. The PE database indicates that the RUC-recommended typical procedure would require 30 such catheters, opposed to 25 noted by the specialty, for a total cost of $555. Consequently, we will not change the PE RVUs for either procedure, although we remain puzzled as to the commenters' specific concerns. We look forward to the specialty's clarification regarding this issue and would urge them to address their concerns through the usual RUC process. We would also like to remind commenters that interim RVUs are published, for new and revised CPT codes, in our final rule each year and are subject to a 60-day comment period at that time. We encourage commenters to observe and utilize the respective comment periods during our annual rulemaking process in order that we may respond timely to issues and concerns.

Comment: We received many comments regarding the use of ''NA'' in Addendum B when used for the ''Nonfacility PE RVUs'' column, the ''Facility PE RVUs'' column, and the occasional code with NA noted in both PE RVU columns. These commenters asked us to provide a clear definition of how the service is paid when the NA is affixed to either PE RVU column in Addendum B which our rule for 2005 fee schedule had PE RVUs listed for the nonfacility. One commenter stated that private payors believe that payment is not made when the NA indicator is listed in Addendum B.

Response: We appreciate the commenters remarks regarding the uncertainty involved with interpreting Addendum B, particular regarding the use of the ''NA'' indicator for the PE RVUs nonfacility and facility columns. Due to the confusion expressed by the commenters surrounding the NA designations, we have added explanations to Addendum A in order to assist the readers of Addendum B. We are also including these definitions here because of this issue's importance. The following 2 explanations also appear in Addendum A of this rule:

- An ''NA'' in the ''Non-facility PE RVUs'' column of Addendum B means that CMS has not developed a PE RVU in the nonfacility setting for the service because it is typically performed in the hospital (that is, for example, an open heart surgery is generally performed in

the hospital setting and not a physician's office).

• Services that have an ''NA'' in the ''Facility PE RVUs'' column of Addendum B are typically not paid using the PFS when provided in a facility setting. These services (which include ''incident to'' services and the technical portion of a diagnostic tests) are generally paid under either the outpatient hospital prospective payment system or bundled into the hospital inpatient prospective payment system payment.

Comment: Other commenters, including specialty organizations, device manufacturers and physicians, noted that CMS had either mistakenly removed PE RVUs in the nonfacility setting or that we had made a decision to stop paying for services where, in Addendum B, an ''NA'' appeared in the proposed rule in the PE RVUs nonfacility column. Another commenter believes that a series of codes for E/M services were incorrectly marked as ''NA'' in the facility setting. These commenters requested that the PE RVUs be restored to these codes.

Response: We apologize to those commenters who found that where, due to the use of a new PE methodology, some of the codes listed in Addendum B of the proposed rule were mistakenly marked with an ''NA'' in either the nonfacility or facility PE RVU column when the service is actually valued in this setting and PE RVUs were listed previously. These mistakes were corrected for Addendum B in this final rule with comment. Most of the commenters requesting the restoration of ''missing'' PE RVUs in the nonfacility setting, though, were mistaken because, in fact, we have not developed nonfacility PE RVUs for these services and Addendum B continues to properly reflect the ''NA'' for the nonfacility PE RVU column.

Comment: Several commenters asked us to create PE RVUs for their services by cross-walking the direct inputs from other services.

Response: All of the requests we received to establish PE RVUs in the nonfacility setting were for services that the PEAC/RUC had either refined or developed without recommendations for PE nonfacility inputs. We would like to remind the specialty organizations that the RUC has a long standing process for the establishment and refinement of PE inputs and encourage all organizations to follow this process.

Comment: A manufacturer requested that we add 15 minutes of clinical labor and a tilt table to the PE database for CPT codes 36475 and 36476—both new codes for CPT 2005.

Response: We agree that the tilt table, for Trendelenberg, is needed for these procedures and are adding this equipment, for the respective service period minutes for each code. However, the commenter's request for additional clinical labor is not timely because the RVUs for these new codes were published as interim in the CY 2005 PFS final rule with comment at that time. As stated in the response above, we remind commenters to observe and utilize the comment period for new and revised codes at the time they are issued in our final rule or utilize the established RUC process, as appropriate.

Comment: We received a comment from an organization representing radiation oncology informing us that equipment for CPT codes 77333 and 77470 was missing.

Response: For CPT 77470, we disagree with the commenter that this service should be assigned equipment. At the January 2004 PEAC meeting, this code was valued specifically to compensate for the clinical labor costs involved with certain high-intensity radiation procedures, such as combined chemotherapy and radiation treatment. CPT 77470 was valued to be billed once throughout the course of treatment, that is typically comprised of 25 fractions. On the other hand, we agree with the commenter that the lack of equipment for CPT codes 77333 and CPT 77332 appears to be an oversight. We believe that the PEAC, at their September 2002 meeting, when considering equipment inputs for CPT code 77334, intended to cross-walk this equipment to the other 2 codes in the family, CPT code 77332 and 77333. Therefore, we are adding this equipment to 77332 and 77333, on an interim basis, and have changed the PE database to reflect this addition for the correlating service period time for each service. However, as explained above, because these codes will be valued in the NPWP and the 2005 PE RVUs will be retained in 2006, this addition will be transparent until such time as the direct inputs are used to establish the PE RVUs for the NPWP services.

Comment: We received comments from several organizations, a specialty society, device manufacturers, IDTFs and physicians regarding concerns about the remote cardiac event monitoring services, including CPT codes 93012, 93226, 93232, 93271, 93733 and 93736, based on the significant reduction in PE RVUs for these services published in our proposed rule using the bottom-up methodology and the elimination of the NPWP. Two of these services, CPT codes 93012 and 90271, were reviewed by the RUC in April 2005 and forwarded as part of the PERC/RUC recommendations in the proposed rule. The commenters noted that these services are typically provided by IDTFs that are equipped for continuous monitoring capabilities 24 hours a day, 7 days a week and require highly trained staff to perform the monitoring of transmissions. The commenters all agreed that the uniqueness of these services makes a poor fit with the usual accounting for direct practice expenses in the physician office. A specialty society requested CMS to work with the involved provider community, that is, the specialty IDTFs, to ensure that the direct and indirect costs of providing these services are adequately reflected in the nonfacility PE RVUs.

Response: We are pleased that the commenters are in agreement that these cardiac event monitoring services may not fit the usual PE model. We are also happy that the specialty society has requested our assistance to work with the specialized provider community in order to ensure more appropriate PE inputs for these services. We look forward to working with the provider organizations before the issuance of our next proposed rule.

Comment: A manufacturer requested that we increase the work and PE values for G0166, external counterpulsation (ECP), because of the significant decrease in PE RVUs for the nonfacility setting in the proposed rule. Specifically, the commenter asked that the labor time be increased to include pre and post service time in addition to the 60 minutes allotted for actual ECP treatment time.

Response: We agree with the commenter that the 60 minutes is inadequate to account for the other activities that the RN performs in relationship to each ECP service. We have assigned some of the standardized times for the activities previously identified by the PEAC as appropriate to this service, as follows: 3 minutes for meet and greet; 2 minutes to prepare the room; 2 minutes to position the patient; 3 minutes for vitals; and 3 minutes for cleaning the room. This extra 13 minutes has been added to the service period in the PE database yielding a total of 73 minutes for the ECP service—although, as discussed previously, this increase will not take effect in 2006 because, with limited exceptions, we will retain the 2005 PE RVU values for existing codes.

Comment: Many commenters, including physicians and a device manufacturer, requested that we increase labor, supplies, and equipment PE values for CPT code 93701, thoracic

electrical bioimpedance (TEB). Their concerns arose from the proposed reduction in PE RVUs in the proposed rule for this service. Some of the commenters told us that the average cost of the equipment from one manufacturer is $38,000, the electrodes are 10.95 ($8.95 with discount) and that the labor time for the TEB procedure ranges from 15–20 minutes. The commenters requested that we adjust the PE values accordingly.

Response: We are sympathetic to the commenters concerns regarding the decrease in PE RVUs reflected in the proposed rule that reflected both the elimination of the NPWP and the bottom-up methodology. For the labor time request, the PE database does contain 20 minutes, although this time was incorrectly cross-walked to the equipment time. We apologize to the commenters regarding this error, and have changed the equipment time to 20 minutes, from 10, in the database. We disagree with the commenters about the inaccuracy of the equipment cost. During the rulemaking process for the CY 2005 fee schedule, at which time we revalued all equipment in the PE database, we identified 2 different brands of equipment used for the TEB service. When the 2 prices are averaged (using $38,000 as noted above by the commenters), the cost of the TEB equipment is $28,625 which is the price listed in the database. We also repriced our supply database during rulemaking for the 2004 fee schedule. The TEB electrodes or sensors are listed at $9.95 in the database and that amount is based solely on a phone quote from the commenting manufacturer. TEB sensors from the other equipment manufacturer range from $4.43 to $6.00 for each patient application. Based on current valuation of the supplies and equipment in the PE database, we are not changing the price of equipment or supplies for the TEB service.

m. Additional PE Issues Raised by Commenters

Comment: We received 2 comments from specialty organizations requesting CMS to re-evaluate the lack of physician work value for the 3 G-codes (G0237, G0238, and G0239) CMS created to describe services to improve respiratory function to reflect the physician's work in overseeing these incident to services. The commenters contend that the addition of CPT 99755, assistive technology assessment, in 2004 created a rank-order anomaly for the respiratory function G-codes. The commenters requested that CMS ask the RUC to evaluate the work for these G-codes.

Response: We disagree with the commenter's contention that a rank order anomaly exists between the respiratory function G-codes and CPT 97755. We were clear when we created these codes during rulemaking for the 2002 fee schedule that the G-codes would make billing of CPT codes 97000–97799 inappropriate for professionals involved in treating respiratory conditions, unless these services are delivered by physical therapists (PTs) and occupational therapists (OTs) and meet other requirements for physical and occupational therapy services. We also disagree that these services are always provided incident to a physician's service because in the CORF setting, where respiratory therapy services are statutorily delineated as a CORF service, the physician's direct supervision is not a requirement and the incident to provisions do not apply. The G-codes enable us to distinguish CORF respiratory therapy and incident to services from the services provided by PTs and OTs under the therapy benefit. Consequently, these G-codes cannot be used to bill for services provided under the physical and occupational benefit category at section 1861(P) of the Act and, as such, cannot create a rank order anomaly with the 97000 series of CPT codes. Although we have not assigned any work values for this final rule with comment, we are still considering the merits of this request and are happy to meet with the commenters prior to the issuance of our next proposed rule to discuss this issue in greater detail. We remind the specialty societies that they can make requests to the RUC to review the G-codes with respect to work values. However, we believe the appropriate review entity would be the HCPAC.

Comment: Several commenters expressed their concern regarding the high-priced supply items in our practice expense database. In their comments, the RUC requested that we consider a different approach for payment of high-priced disposable medical supplies, particularly with respect to new technology supply items—where prices commonly decrease within 6–12 months after being distributed into a wider market—as these services move into the physician's office. As an alternative, the RUC strongly encourages CMS to review and re-price medical supplies, priced at or above $200, on an annual basis. Another commenter noted that our listed price of $677 for the endovenous laser kit used for CPT 36478 is apparently in error because it is readily available at $250–$350 and listed four suppliers who distribute this supply in the noted price range.

Response: We appreciate comments and remarks. The RUC's comments regarding high cost medical supplies and the need to review these prices on a more frequent basis than every 5 years. Because we are committed to ensuring that the prices for supplies and equipment in the PE database are accurate, we also want to account in some way for the volatile nature of prices for new technology. We will consider options for revaluing these high cost ''new tech'' supply items and include a discussion of this issue in the next proposed rule

Comment: We received a comment from an organization representing services of audiologists noting that the salary for audiologists and the equipment for their services are too low or out of date.

Response: During the rulemaking process for the 2005 fee schedule, we revalued all equipment in the PE database, and requested specialty input at that time. To the extent that there have been changes since last year, we recommend that the organization utilize the establish RUC process. We would also encourage the commenter to supply us with updated salary information so that we may better address their other concern.

Revisions to CPT Code Series 21076 Through 21087

We also want to note that, at the request of the RUC, we have been working directly with representatives of maxillofacial prosthetics to refine the PE inputs for the CPT code series 21076 through 21087. They have submitted spreadsheets to us for labor, supplies and equipment, and much of this information has been entered in the PE database although, as discussed above, the 2005 PE RVUs will be retained for 2006. We will continue to work with the specialty to refine these inputs, verifying prices and quantities, prior to the issuance of our next proposed rule.

B. Geographic Practice Cost Indices (GPCIs)

Section 1848(e)(1)(A) of the Act requires us to develop separate GPCIs to measure resource cost differences among localities compared to the national average for each of the three fee schedule components. While requiring that the PE and malpractice GPCIs reflect the full relative cost differences, section 1848(e)(1)(A)(iii) of the Act requires that the physician work GPCIs reflect only one-quarter of the relative cost differences compared to the national average.

As discussed in the August 8, 2005 proposed rule (70 FR 45783), section 1848(e)(1)(E) of the Act, as amended by section 412 of the MMA, established a floor of 1.0 for the work GPCI for any locality where the GPCI would otherwise fall below 1.0. This 1.0 work GPCI floor was used for purposes of payment for services furnished on or after January 1, 2004 and before January 1, 2007. This 1.0 floor will remain in effect in 2006.

Section 602 of the MMA added section 1848(e)(1)(G) of the Act, which sets a floor of 1.67 for the work, PE, and malpractice GPCIs for services furnished in Alaska between January 1, 2004 and December 31, 2005 for any locality where the GPCI would otherwise fall below 1.67. Effective January 1, 2006, this provision will end. In the proposed rule, we indicated the 2006 GPCIs for Alaska will be 1.017 for physician work, 1.103 for PE, and 1.029 for malpractice.

Payment Localities

In the August 8, 2005 proposed rule (70 FR 45783), we stated that we look for the support of a State medical society as the impetus for changes to existing payment localities. Because the GPCIs for each locality are calculated using the average of the county-specific data from all of the counties in the locality, removing high-cost counties from a locality will result in lower GPCIs for the remaining counties. Because of this redistributive impact, we have refrained, in the past, from making changes to payment localities unless the State medical association provides evidence that any proposed change has Statewide support.

After the publication of the CY 2005 final rule, the California Medical Association (CMA) submitted a proposal for a demonstration project that was the same as its proposal submitted in response to the August 5, 2004 PFS proposed rule. The CMS proposed removing ten counties from the existing ''Rest of California'' payment locality and creating ten new payment localities. Additionally, reductions to the payments to the Rest of California locality, would be balanced by payment contributions from the other payment localities in the State.

There were several aspects of the proposal that made implementation problematic for us under our demonstration authority. For example, physicians whose payments would decrease under the demonstration could challenge the validity of a new locality configuration established without providing them the opportunity to comment through the regulatory process (as is our normal process for making locality changes). In particular, physicians who are not members of county medical societies or the CMA, or did not agree to participate in the proposed demonstration may have challenged its implementation.

Also, the Medicare PFS currently uses identical GPCIs to pay for services provided in an area by both physicians and nonphysician providers (such as podiatrists, optometrists, physical therapists, and nurse practitioner). Changing the locality configuration for medical doctors and doctors of osteopathic medicine, but not for other professionals, would have some peculiar results that were not addressed in the CMA proposal. For example, in areas where the GPCIs would be reduced under the demonstration, some practitioners not participating under the demonstration (such as physical therapists) could be paid more than physicians in the same locality. Conversely, where the GPCIs would be increased under the demonstration, there would likely be complaints from the nonphysician practitioners not included in the demonstration.

Nonetheless, we do recognize the potential impact of wide variations in the practice costs within a single payment locality. In the CY 2005 final rule, we noted that we received many comments from physicians and individuals in Santa Cruz County expressing the opinion that Santa Cruz County should be removed from the Rest of California payment locality and placed in its own payment locality. The county-specific GAF of Santa Cruz County is 10 percent higher than the Rest of California locality GAF. Santa Cruz County is adjacent to Santa Clara County and San Mateo County. Santa Clara and San Mateo Counties have two of the highest GAFs in the nation. The published 2006 GAF for the Rest of California payment locality is 24 percent less than the GAFs of Santa Clara and San Mateo.

Sonoma County is also part of the Rest of California payment locality. The county-specific GAF of Sonoma County is 8 percent higher than the Rest of California locality GAF. Sonoma County is bordered by Marin County and Napa County. Using published 2006 values, the payment locality that includes Marin and Napa counties has the fourth highest GAF in the nation, and is 13 percent higher than the GAF of the Rest of California payment locality.

We recognize that changing demographics over time may lead to significant payment disparities in particular circumstances. We rely upon State medical societies to identify and propose consensus approaches to resolving these disparities, because there are redistributive impacts in the ''budget neutral'' process within a State when new localities are created (or existing ones reconfigured). Yet we also recognize our responsibility for establishing fee schedule areas. In the proposed rule, to assure the maximum opportunity for public discussion and comment to identify a consensus approach, we listed alternative locality configurations that we had examined, including:

- The CMA demonstration approach comparing county-specific GAFs to the payment locality GAF, and designating any county with a county-specific GAF at least 5 percent higher than its locality GAF as a new locality;
- An approach that sorts counties by descending GAFs and compares the highest county to the second highest county. If the difference between these two counties is 5 percent or less, they are included in the same locality. The third highest county GAF is then compared to the highest county GAF and so on, until the next county GAF is not within 5 percent of the highest county GAF. At that point, the county GAF that is more than 5 percent lower than the highest county GAF becomes the comparison for the next lowest county GAF, to create a second locality. This process is repeated down throughout all of the counties;
- An approach that compares the county with the highest GAF to the Statewide average, removing counties that are 5 percent or more than the Statewide average; and
- An approach that bases GPCI payment localities on Metropolitan Statistical Areas as defined by the Office of Management and Budget.

However, because these reconfigurations would result in significant redistributions across most California counties, we simply proposed the approach that would have the least impact on other counties. We proposed that Santa Cruz and Sonoma Counties (the two counties with the most significant disparity between the assigned Rest of California GAF and the county-specific GAF) be removed from the Rest of California payment locality and that each would be its own payment locality. We invited and received comments regarding this proposal and possible alternative approaches to address this issue. We were particularly interested in whether the CMA supported this approach. Those comments and our responses are discussed below.

The issue of payment locality designation in light of changing economic and population trends will be

of importance to us for the foreseeable future. We also indicated in the proposed rule that we are interested in other solutions to the problem, and with any ideas or suggestions that will help resolve the problems associated with the designation and revision of payment localities. We would use those ideas and suggestions in developing any future proposal that would be subject to comment through the rulemaking process.

Comment: Numerous comments from the beneficiaries and health care providers in Santa Cruz and Sonoma Counties, and from several members of the Congress, including a U.S. Senator from California, supported our proposed change. These comments focused on the high costs of practicing in Santa Cruz and Sonoma Counties and were appreciative of the proposal. Most supporters referred to studies that have shown the high costs of working in Santa Cruz and Sonoma Counties have resulted in physicians restricting their practices or withdrawing from practice altogether. According to the commenters, this has made it more difficult for Medicare beneficiaries to find doctors in those counties. These commenters feel that our proposed change will encourage physicians to continue to treat Medicare patients in their Santa Cruz and Sonoma County practices.

Response: These two counties currently have the most significant disparities between their present GAFs and their county-specific GAFs. They are also bordered by counties with significantly higher GAFs. As we stated earlier in this section and in the proposed rule, we have received many comments in the past expressing concern that these disparities have led some practitioners to relocate their practices out of these counties, creating potential access problems.

The proposal was an attempt to balance the interests of physicians and nonphysician practitioners and their patients in Santa Cruz and Sonoma Counties with the interests of providers and patients in the other counties in the Rest of California. We noted in the proposed rule that the 2006 Rest of California GAF would be 1.011, compared to the 2005 GAF of 1.012. Absent this proposal, the 2006 Rest of California GAF would be 1.017 (2006 is the second year of the transition to the new GPCIs and GAFs incorporating updated data).

Comment: We also received comments opposing the proposal from numerous providers and medical associations in the current Rest of California payment locality. In addition, several members of the Congress wrote letters opposing the proposed change.

The CMA pointed to the fact, which is the result of the budget neutrality requirement for administrative actions to modify GPCIs, that the Rest of California locality would be negatively impacted. The CMA also notes that the proposal does not address the other localities it identified in its demonstration proposal. These views were echoed by the other commenters objecting to the proposal.

Response: It is indicative of the difficult nature of this issue that many of the same commenters who expressed disappointment that our proposal did not address all of the other counties that CMA identified in its demonstration proposal were also concerned that the proposal would simultaneously result in a reduction of the GPCIs for the Rest of California payment locality. Under our current statutory authority, it is well known that changes to the payment localities must be implemented in a budget neutral manner. Therefore, it is not possible to fully meet both objectives without legislation to provide additional funding for physician payments in California.

While we appreciate the situation of practitioners in Santa Cruz and Sonoma Counties as described above, we also acknowledge the concerns of those in the Rest of California payment locality about the negative payment impact of removing the GPCI data for Santa Cruz and Sonoma Counties, and the lack of support from the CMA for an administrative solution to these payment concerns. As we mentioned earlier in this section, our proposal was designed to balance these two interests.

As we have stated repeatedly in the past, we believe payment locality reconfigurations should be supported broadly across the State. It was our belief that the proposal we presented, which actually would have had the smallest possible negative impact on the Rest of California's GAF, might meet that criterion. However, based on the comments we received opposing the proposal, particularly those from the CMA, it is apparent that this proposed change is not acceptable to the majority of commenters at this time.

Comment: The CMA indicated that it supports a nationwide legislative solution that would provide additional funding for physicians in counties adversely affected by locality reconfigurations. The CMA states ''this is the only GPCI solution that we are supporting at this time.''

The Medicare Payment Advisory Commission (MedPAC) comments that the locality boundaries have not had a complete review since 1997 and that economic and population trends are likely to have changed since that time. MedPAC is studying these issues, and encourages CMS to do so as well, with the goal of revisiting the boundaries of all payment localities nationwide.

We also received a comment from a member of the Congress urging us to conduct a national examination of the definitions of payment localities. The commenter recommended that we propose a method to reconfigure payment localities to be effective January 1, 2008. The commenter also recommended that we develop a process for periodically reviewing payment localities.

Response: As we stated earlier in this section and in the proposed rule, we are interested in all ideas that will help resolve the problems associated with the designation and revision of payment localities. Clearly, as illustrated by the situation discussed earlier in this section, one of the most significant issues to be addressed is the redistributive nature of changes to the payment localities in a budget neutral context.

There are currently 89 separate payment localities. Of these, 34 are Statewide localities. Our last comprehensive evaluation of the definition and composition of the payment localities was discussed in the July 2, 1996 proposed rule (61 FR 34615) and the November 22, 1996 final rule (61 FR 59494). The localities existing at that time, which were developed by the local Medicare contractors, served as building blocks for the current localities (at the time, there were 210 separate localities, 22 of them were Statewide localities).

We stated at the time that our major goals were to simplify payment areas and payment differences among adjacent geographic areas while maintaining accuracy in tracking input price differences among areas. There is an inherent trade-off between these two goals. Thus, at one extreme is a set of Statewide localities with no intra-state geographic adjustments; very simple, but less descriptive of input price differences. At the other extreme is a separate locality for each county; maximum input price adjustment for geographic variation, but operationally very cumbersome, expensive to develop and maintain, and potentially very confusing for providers.

We do not disagree with the view that a comprehensive evaluation of the current payment localities is due, and we look forward to working cooperatively with MedPAC in that regard. We are examining all viable

options that will meet the general objectives discussed above. We would note, however, that our goals for this analysis are very similar to those we expressed in 1996.

Comment: A private insurer is opposed to our proposal because it increases the number of payment localities which increases commercial payer administrative costs. The insurer suggests we reduce the number of California payment localities from 10 to 3.

Response: While we appreciate and, as a matter of general policy, agree that it would be preferable to minimize the number of separate payment localities wherever possible, we do not believe that reducing the number of payment localities would resolve the issues discussed above.

Comment: We received comments from a medical clinic in Wisconsin and a research and management organization in Colorado. These commenters stated that CMS is using improper data to create the GPCIs. The commenters suggest we change the wage proxy categories to include physicians and remove physician work from the GPCI calculation. They further state that ''Medicare payments are a primary stimulus in attracting greater numbers of physicians to high payment localities''. The commenters also suggest we look for alternative data sources for rent data.

Response: The CY 2005 final rule contained responses to commenters raising the same issues related to the data used to calculate the GPCIs as those noted above (69 FR 66260). Because the data used to calculate the GPCIs was not part of the proposed rule, we refer the commenter to that document rather than repeat that discussion here. We also note that we continue to evaluate other potential sources of data to use to calculate the GPCIs.

We are disappointed that there was limited support for the proposal to create new, separate payment localities for Santa Cruz and Sonoma Counties. As we noted above, the proposal was designed to balance concerns of practitioners in higher-cost Santa Cruz and Sonoma Counties with the concerns of those in the Rest of California payment locality about the negative payment impact resulting from removal of the GPCI data for Santa Cruz and Sonoma counties from the Rest of California GPCI calculation. Because of the nearly complete lack of support for this proposal outside the two positively impacted counties, we have decided to withdraw this proposal at this time. As noted above, we intend to work with MedPAC and other interested parties toward a more comprehensive evaluation of potential refinements of the payment localities.

Under section 1848(e)(1)(E) of the Act, the floor of 1.67 for the work, PE, and malpractice GPCIs for services furnished in Alaska ends as of January 1, 2006. Therefore, as of that date, the GPCIs for Alaska will be 1.017 for physician work, 1.103 for PE, and 1.029 for malpractice costs.

C. Malpractice Relative Value Units (RVUs)

We discussed several proposed technical changes and other issues related to the calculation of the malpractice RVUs in the proposed rule. These are summarized below, along with discussions of the comments we received and our responses.

1. Five Percent Specialty Threshold

We are concerned that the malpractice RVUs could be inappropriately inflated or deflated due to irregular data based upon incorrectly reported specialty classifications and have examined the impact of establishing a minimum percentage threshold for any procedure performed by any specialty before the risk factor of that specialty is included in the malpractice RVU calculation of a particular code. We proposed excluding data for any specialty that performs less than 5 percent of a particular service or procedure from the malpractice RVU calculation for that service or procedure and discussed the code-specific impact of implementing this proposed threshold. Our assumption was that the infrequent instances of these specialties in our data represent aberrant occurrences and removing the associated risk factor from the malpractice RVU calculation would improve the accuracy and stability of the RVUs. This was based on our belief that removing data attributable to specialties that occur in our data less than 5 percent of the time would most appropriately balance the objective to identify irregular data (claims with a specialty identified that is highly unlikely to have performed a particular procedure) while including specialties that perform a procedure a small percentage (but at least 5 percent)of the time.

We excluded evaluation and management (E&M) services from the analysis. Medicare claims data show that E&M services are performed by virtually all physician specialties. Therefore, in the case of E&M codes, it is likely that even the low relative percentages of performance by some specialties would accurately represent the provision of the service by those specialties.

For all services other than E&M services, we stated our belief that removing data attributable to specialties that occur in our data less than 5 percent of the time would most appropriately balance the objective to identify irregular data (claims with a specialty identified that is highly unlikely to have performed a particular procedure) while including specialties that perform a procedure a small percentage of the time. The higher the threshold, the more likely it would result in the removal of data for specialties actually performing the procedure, while a lower threshold would be more likely to fail to remove some irregular data, particularly for low-volume codes (fewer than 100 occurrences, where each claim represents 1 or more percentage points).

The overall impact of removing the risk factor for specialties that occur less than 5 percent of the time in our data for a procedure is minimal. There is no impact on the malpractice RVUs for over 5,280 codes, and there is an impact of less than 1 percent on the malpractice RVUs for over 1,300 additional codes. Only 16 codes decrease by at least 0.1 RVUs, with the biggest decrease being a negative 0.28 impact on the malpractice RVU for CPT code 17108, *Destruction of skin lesions,* from a current RVU of 0.82 to a proposed RVU of 0.54.

Conversely, there are 219 codes for which RVUs increase by at least 0.1, the largest increase being a positive 0.81 RVU increase for CPT code 61583, *Craniofacial approach, skull,* from a current RVU of 8.32 to a proposed RVU of 9.13. Among codes whose malpractice RVUs would increase under our proposal, 646 have increases of less than 1 percent. The impact analysis section of this proposed rule examines the effects of this proposed change by specialty.

Comment: Numerous commenters supported the 5 percent specialty threshold. Several commenters suggested that we apply the threshold to the E&M codes.

Response: We appreciate the commenters' support of this change to our methodology. Regarding the exclusion of E&M codes from our analysis, we note our rationale as stated above in this section. The comments we received did not address our concern that all specialties use these codes. Therefore, we still believe it is appropriate not to apply the 5 percent specialty threshold to the E&M codes.

Comment: We received a comment recommending the threshold be lowered to 1 percent. The commenter is concerned that a 5 percent threshold inappropriately removes some

specialties actually performing interventional radiology services. The example of CPT code 35476 (percutaneous venous angioplasty) was provided. The commenter noted that CMS's proposed 5 percent threshold removed the risk factors for general surgeons and vascular surgeons, resulting in a decrease in the malpractice RVUs for this code. The commenter states this was contrary to our objective to remove irregular data because both of these specialties actually perform this procedure, and that a 1 percent threshold would better retain those specialties actually providing the service while still removing irregular data.

Response: In the case of CPT code 35476, the risk factors for the two specialties that were removed resulted in a decrease in the RVUs for this code; however, we review these data on a regular basis and if, in the future, the data support it, we will change the RVUs accordingly. We note that the majority of commenters supported a 5 percent threshold as reasonable. We do not believe a 1 percent threshold, as suggested by the commenter, is reasonable as this threshold would not be an effective screen for claims with a specialty identified that is highly unlikely to have performed a particular procedure. However, we will continue to assess whether a different threshold may ensure irregular data are removed without also removing data for specialties that actually perform the service.

2. Specialty Crosswalk Issues

Malpractice insurers generally use five-digit codes developed by the Insurance Services Office (ISO), an advisory body serving property and casualty insurers, to classify physician specialties into different risk classes for premium rating purposes. ISO codes classify physicians not only by specialty, but in many cases also by whether or not the specialty performs surgical procedures. A given specialty could thus have two ISO codes, one for use in rating a member of that specialty who performs surgical procedures and another for rating a member who does not perform surgery.

Medicare uses its own system of specialty classification for payment and data purposes. Therefore, to calculate the malpractice RVUs, it was necessary to map Medicare specialties to ISO codes and insurer risk classes, and in some instances to crosswalk unassigned specialties to the most approximate existing ISO codes and risk classes.

We stated in the CY 2005 final rule that we would continue to work with the AMA RUC's Professional Liability Insurance (PLI) Workgroup to address any potential inconsistencies that may still exist in our methodology. Based upon this commitment, the RUC PLI Workgroup forwarded various recommendations for our consideration. The RUC developed its recommendations based upon comments submitted to them by physician specialty organizations.

As discussed in the August 8, 2005 proposed rule, the Workgroup believes the risk factors assigned to certain professions overestimate the insurance premiums for these professions and, based on its recommendations, we proposed revising the risk factor for the following specialties to a risk factor of 1.00: clinical psychology; licensed clinical social work; psychology; occupational therapy; opticians and optometrists; chiropractic and physical therapy. We invited comment from representatives of the affected specialties and others regarding the appropriateness of this proposal, as well as other specialty crosswalks and suggestions for reliable sources of actual malpractice premium data for nonphysician groups.

The RUC PLI Workgroup also believed that a number of professions that were assigned to the average for all physicians risk factor should be removed from the calculation of malpractice RVUs altogether and recommended excluding data from the following professions: Certified clinical nurse specialist; clinical laboratory; multispecialty clinic or group practice; nurse practitioner; physician assistant; and physiological laboratory (independent). We agreed with this recommendation and proposed to establish malpractice RVUs based upon the mix of specialties exclusive of the above specialties and professions.

The PLI Workgroup also made recommendations for changing the crosswalks for risk factors for the following specialties which we did not accept: Certified registered nurse anesthetists; colorectal surgeons; gynecologists; and oncologists. We did not propose changes to the current crosswalks for these specialties and professions because we believe the current crosswalks we are using for these specialties appropriately reflect the types of services they provide.

Comment: One commenter objected to our proposed change in the crosswalk to the lowest current risk factor of 1.00 for opticians and optometrists. The commenter stated that the recommendation from the RUC was not based on examination of the premium data or any other objective evidence. However, another commenter supported the proposal to crosswalk optometrists and opticians to the lowest current risk factor of 1.00, arguing this more appropriately reflects the actual level of risk assumed during the performance of procedures.

A commenter objected to the proposed crosswalk change to 1.00 for clinical psychologists, licensed clinical social workers, and psychologists because the commenter believes that the malpractice insurance costs for these nonphysician practitioners are well below those paid by psychiatrists.

Response: The proposed changes to the risk adjustment factor crosswalks were based on our agreement with the RUC PLI Workgroup's assertion that these nonphysician professionals incur costs most similar to the lowest cost physician specialty. Because we do not have actual premium data for these professional groups, it is necessary to select an appropriate crosswalk category. We proposed to change the crosswalks for these specialties because, absent actual premium data, we agree with the RUC that these groups very likely do not incur malpractice costs on par with the average physician specialty.

In its comments, the RUC points out that each of the professions for which we proposed to change the malpractice crosswalk is represented on the RUC's Health Care Professional Advisory Committee (HCPAC). The HCPAC agreed that these professions should review their premium data and report back to the HCPAC at its September 29, 2005 meeting. Subsequently, on October 6, 2005 (after the close of the public comment period), the RUC submitted the results of these reviews.

The RUC submitted to us after the close of the public comment period malpractice insurance premium data from many of these nonphysician professional groups. Because these data were received after the close of the comment period, and we believe it is important to allow the affected specialties the opportunity to comment on changes to the crosswalks, we are not incorporating these data in this final rule with comment. However, we would note that the data suggest that the annual premiums paid by these groups are below the average amounts paid by allergists and immunologists, the lowest premium cost physician specialties.

We plan to continue to examine this issue in conjunction with the RUC's PLI Workgroup before the 2007 proposed rule. Based on the fact that commenters did not provide any alternative data to suggest the crosswalks we proposed

were inappropriate, we will adopt our proposals for 2006 without change.

Comment: One commenter supported our proposal to change the crosswalk for services of occupational therapists to 1.00, but suggests that the crosswalk should not be to allergy and immunology. Instead, the commenter recommended a crosswalk to physical medicine and rehabilitation.

Response: We appreciate the commenter's support of our proposal. With regard to the commenter's recommendation to crosswalk to the specialty of physical medicine and rehabilitation, we would note that the risk factor for this specialty is 1.26 rather than 1.00. As noted above, because the comments we received did not contain any alternative data to suggest the crosswalks we proposed were inappropriate, we are adopting our proposals for 2006.

Comment: Several commenters urged us to reconsider our proposal to not accept the RUC PLI's recommendations to crosswalk: the specialty of gynecologist/oncologist to surgical oncology; certified registered nurse anesthetists (CRNAs) to anesthesiology; and, colorectal surgery to general surgery.

Commenters also suggested separate surgical and nonsurgical risk factors for urology, and that hand surgery be crosswalked to orthopedic surgery (without spine).

Response: With respect to the commenters' recommendation to crosswalk gynecologist/oncologist to surgical oncology, the commenters did not substantially justify the argument that the professional liability premiums of the specialty are similar to those of surgical oncologists; however, we will analyze the data for this suggestion for possible future consideration. Commenters noted that CRNAs are currently crosswalked to general surgery, which means that CRNAs have a higher risk factor than anesthesiologists. These commenters recommended that CRNAs be crosswalked to anesthesiology and we accept this recommendation.

For the request to crosswalk colorectal surgery to general surgery, the specialty of colorectal surgery was not crosswalked. Instead, we used actual premium liability insurance data collected for this specialty. Consequently, we disagree that this specialty should be crosswalked to another specialty. As stated previously and in the proposed rule, we only crosswalked specialties for which no premium data were collected.

With regard to the comments regarding separate surgical and nonsurgical risk factors for urology, we would be interested in further information regarding the appropriateness of this change.

For the request to crosswalk hand surgery to orthopedic surgery, we note that, similar to colorectal surgery above, we used actual premium liability insurance data collected for this specialty. Consequently, we disagree that this specialty should be crosswalked to another specialty.

Comment: The RUC supported our proposal to remove the risk adjustment data for the following professions and providers: certified clinical nurse specialist; clinical laboratory; multispecialty clinic or group practice; nurse practitioners, physician assistants; and physiological laboratory (independent).

Response: We appreciate these supportive comments for this proposed change.

3. Cardiac Catheterization and Angioplasty Exception

In the November 2, 1999 final PFS rule (64 FR 59384), we applied surgical risk factors to the following cardiology catheterization and angioplasty codes: 92980 to 92998 and 93501 to 93536. This exception was established because these procedures are quite invasive and more akin to surgical than nonsurgical procedures.

In the CY 2005 (69 FR 66275), we discussed changes to the list of codes that would fall under the exception. In response to a request from the RUC's PLI Workgroup, we proposed to add the following CPT codes to the existing list of codes under the exception: 92975; 92980 to 92998; and 93617 to 93641.

Comment: Several commenters supported the changes made for the cardiac catheterization and angioplasty exception.

Response: We appreciate the supportive comments for this proposed change.

4. Dominant Specialty for Low-Volume Codes

The final recommendation from the PLI Workgroup was to use the dominant specialty approach for services or procedures with fewer than 100 occurrences, and to apply this approach to the list of 1,844 services supplied by the workgroup. The PLI Workgroup worked in conjunction with various specialty organizations to identify the dominant specialty that performs each service.

We did not propose to adopt this methodology and noted that low volume procedures or services are not necessarily performed by only one specialty. As noted previously, we would distinguish between excluding data presumed to be erroneous from data reflecting utilization by specialties that perform a service but are not the dominant specialty. However, we acknowledge that there may be instances where irregular data exist that would not be identified and removed by our proposed 5 percent threshold discussed previously. We will continue to work with the RUC PLI Workgroup examine this issue in the future.

Comment: Numerous commenters opposed our policy to use actual specialty data rather than dominant specialties and suggested that we adopt the RUC recommendations.

Response: As we stated in the PFS proposed rule (70 FR 45786), we believe that basing payment on all specialties that perform a particular service ensures that the actual professional liability insurance costs of all specialties are included in the calculation of the malpractice RVUs. Therefore, we do not believe it would be appropriate, even for these low-volume services, to include only the dominant specialty if other specialties regularly provide the service.

5. Collection of Premium Data

Although this issue was not part of the proposed rule, many commenters suggested that we use alternative sources for our premium data.

Comment: Some commenters suggested we used data supplied by the Physicians Insurers Association of America (PIAA) or directly from physician providers.

Response: We are currently investigating the usefulness of the PIAA data and once our evaluation of the data is complete we will make a decision. We are not considering using physician provider self-reported premium costs.

Final Decision

We are implementing the proposed 5 percent threshold and specialty crosswalk changes discussed in the proposed rule. After considering all of the other comments received, we are not making other changes to the calculation of the malpractice RVUs.

D. Medicare Telehealth Services

1. Requests for Adding Services to the List of Medicare Telehealth Services

As discussed in the August 8, 2005 PFS proposed rule (70 FR 45786), section 1834(m) of the Act defines telehealth services as professional consultations, office and other outpatient visits, and office psychiatry services identified as of July 1, 2000 by CPT codes 99241 through 99275, 99201

through 99215, 90804 through 90809, and 90862. In addition, the statute requires us to establish a process for adding services to or deleting services from the list of telehealth services on an annual basis.

In the December 31, 2002 **Federal Register** (67 FR 79988), we established a process for adding or deleting services to the list of Medicare telehealth services. This process provides the public an ongoing opportunity to submit requests for adding services. We assign any request to make additions to the list of Medicare telehealth services to one of the following categories:

- Category #1: Services that are similar to office and other outpatient visits, consultations, and office psychiatry services. In reviewing these requests, we look for similarities between the proposed and existing telehealth services for the roles of, and interactions among, the beneficiary, the physician (or other practitioner) at the distant site and, if necessary, the telepresenter. We also look for similarities in the telecommunications system used to deliver the proposed service (for example, the use of interactive audio and video equipment.)
- Category #2: Services that are not similar to the current list of telehealth services. Our review of these requests includes an assessment of whether the use of a telecommunications system to deliver the service produces similar diagnostic findings or therapeutic interventions as compared with the face-to-face ''hands on'' delivery of the same service. Requestors should submit evidence showing that the use of a telecommunications system does not affect the diagnosis or treatment plan as compared to a face-to-face delivery of the requested service.

Since establishing the process, we have added the psychiatric diagnostic interview examination and ESRD services with 2 to 3 visits per month and 4 or more visits per month to the list of Medicare telehealth services (although we require at least one in-person visit a month by a physician, clinical nurse specialist, nurse practitioner, or physician assistant to examine the vascular access site).

Requests for adding services to the list of Medicare telehealth services must be submitted and received no later than December 31st of each year to be considered for the next proposed rule. For example, requests submitted before the end of CY 2004 are considered for the CY 2006 proposed rule. For more information on submitting a request for an addition to the list of Medicare telehealth services, visit our web site at *www.cms.hhs.gov/physicians/telehealth.*

We received the following public requests for additional approved services in CY 2004: (1) Individual medical nutritional therapy (MNT) as described by HCPCS codes G0270, 97802 and 97803; (2) group MNT (HCPCS codes G0271 and 97804); (3) individual diabetes outpatient self-management training (DSMT) services (HCPCS code G0108); (4) Group DSMT (HCPCS code G0109); and (5) modification of the definition of an interactive telecommunications system for purposes of furnishing a telehealth service.

After reviewing the public requests, we proposed to add individual MNT as represented by HCPCS codes G0270, 97802 and 97803 to the list of Medicare telehealth services. We also proposed to add individual MNT to the list of Medicare telehealth services at § 410.78 and § 414.65. Moreover, because a certified registered dietitian or other nutrition professional are the only practitioners permitted by law to furnish MNT, we proposed to revise § 410.78 to add a registered dietitian and nutrition professional as defined in § 410.134 to the list of practitioners who may furnish and receive payment for a telehealth service.

We did not propose to add any additional services to the list of Medicare telehealth services or to make any changes to the definition of an interactive telecommunications system for CY 2006.

For further information on our proposals, see the **Federal Register** dated August 8, 2005 (70 FR 45786).

Individual MNT

Comment: Many commenters supported our proposal to approve individual MNT for telehealth and to add a registered dietitian and nutrition professional to the list of practitioners authorized to furnish and receive payment for Medicare telehealth services. Commenters stated that adding MNT to the list of Medicare telehealth services would improve access and services for patients in remote areas where traditional MNT services may not be readily available. For example, a State dietetic association mentioned that in many cases, patients need to drive for more than an hour to receive MNT services and that the ability to furnish individual MNT as a telehealth service will provide great benefit to rural Medicare beneficiaries. Furthermore, a renal association stated that limited access to nutritional therapists is problematic for patients with stage 3 and 4 kidney disease who are located in rural or isolated areas. The commenter explained that nutritional counseling is an important tool for helping beneficiaries improve their nutritional status and in controlling levels of key electrolytes such as potassium and phosphorous. Several MNT practices also urged us to adopt our proposal to approve individual MNT for telehealth. Another commenter supported the addition of individual MNT, however stated that more conclusive data regarding efficacy is needed before further expansion.

Response: We agree with the commenters that approving individual MNT for telehealth would help provide greater access to registered dietitians and other nutritional professionals for beneficiaries in rural and or isolated areas.

Comment: A few commenters believe that MNT should not be approved as a Medicare telehealth service. For instance, a certified diabetes educator (CDE) stated that it would be very difficult to accurately assess cognitive and literacy levels, emotional state and motivation without seeing the patient. The commenter also believes that face-to-face interaction for assessment, establishment of goals, and reviewing written materials is essential. The commenter expressed support for using telehealth to furnish MNT in very limited circumstances, for example if there was no access to an educator within 50 miles or if the patient was homebound. One commenter contends that it would be difficult to assess a patient's understanding of the dietary prescription, nutrient content of each food group, portion control and information provided by food labels, especially for beneficiaries who cannot read and or have a vision impairment that prevents them from reading fine print. Moreover, another commenter believes that individual MNT includes skill-based training beyond an individual assessment, not unlike teaching insulin administration or blood glucose monitoring. The commenter stated that the skills taught in MNT cannot be verbally assessed through distance education.

Response: As discussed in the proposed rule, we believe that individual MNT is similar in nature to an office or other outpatient visit (which is defined in the law as a Medicare telehealth service). We believe that the components of an E/M office visit involve a similar level of patient counseling for following a treatment plan as compared to individual MNT. We also believe that a registered dietitian at the distant site, along with an appropriate medical professional

with the beneficiary at the originating site, could adequately assess and adjust to the beneficiary's ability to understand and follow his or her nutritional plan.

We do not agree with the commenter that the same level of physical, skill-based training that is required in an individual DSMT session, (for example, teaching a Medicare beneficiary the skills necessary for the self-injection of insulin), is a requirement for individual MNT.

Comment: One commenter requested that we clarify whether we would pay a physician practice for individual MNT furnished as a telehealth service when a registered dietitian or other nutrition professional reassigns his or her right to bill for payment to the physician practice as an employer.

Response: As discussed in the CMS claims processing manual (Pub. 100–04, chapter 1, section 30.2.6), if the employer/employee reassignment exception is met, and the person furnishing the service and the entity wishing to bill are both enrolled in Medicare and each have their own billing number, then we could make payment to the physician practice for the MNT service.

Group Medical Nutritional Therapy (MNT) and Diabetes Self-Management Training Services (DSMT)

Comment: Some commenters agreed with our proposal not to add DSMT to the list of Medicare telehealth services. For instance, one commenter wrote that DSMT can not be done as a telehealth service because in-person interaction with the client is crucial for assessing the skill development necessary for managing diabetes. Additionally, two certified diabetic educators (CDE) stated that DSMT can not be adequately furnished as a telehealth service and agreed with our proposal not to add DSMT to the list of Medicare telehealth services. Furthermore, another commenter stated that face-to-face interaction for assessment, establishment of goals, and reviewing written materials is essential for DSMT.

Response: As discussed in the proposed rule, we believe that DSMT is not similar to the current list of Medicare telehealth services and requires conclusive evidence showing that the use of a telecommunications system is an adequate substitute for the in-person delivery of DSMT.

Comment: A few commenters believe group MNT and group DSMT are similar in nature to the current list of Medicare telehealth services and therefore should be approved for telehealth under category 1 criteria. The commenters contend that the same presentation material, text books, manuals, DVD's and on site support staff are used whether group DSMT or group MNT is furnished in-person or through an interactive audio and video telecommunications system. The commenters stated that the practitioner would conduct the same training session for a telehealth service as they would in-person, and they believe that the interactive differences between group MNT and group DSMT and the current Medicare telehealth services should not be used as a basis for denying these services. The commenters believe that the criteria for approving group MNT and group DSMT should be based on whether the use of a telecommunications system is equivalent to the in-person delivery of the requested service. Moreover, commenters argue that no group services would ever be approved if we base approval upon whether the interactive dynamic of the requested service is similar to existing telehealth services and requested us to add group MNT and group DSMT as a precedent by which other future group service requests could be measured.

Response: Category 1 requests are reviewed to ensure that the roles of, and interaction among, the beneficiary and physician (or other practitioner) of the requested service are similar to the current telehealth services, for example office and other outpatient visits and consultation services. In other words, the roles of, and interaction among, the beneficiary and physician (or practitioner) is the criterion used to determine whether the requested service is similar to the current telehealth services.

Since the interactive dynamic of group MNT and group DSMT is not similar to the current list of telehealth services, the request to add these services was assigned to category 2. For category 2 services, we assess whether the use of an interactive audio and video telecommunications system to deliver the requested service is equivalent to the in-person delivery of the service. To that end, we review any comparative analyses submitted by the requestor illustrating that the use of a telecommunications system is an adequate substitute for the in-person delivery of the requested service. If the requestor were to submit studies indicating that beneficiaries receiving group MNT and group DSMT comprehend and apply the training material as well by telehealth as in person, we would reconsider approving group MNT and group DSMT for telehealth.

Comment: The same group of commenters also believe that individual DSMT is similar to the existing list of telehealth services and should be approved as a category 1 request. The commenters contend that a telepresenter would be able to facilitate the ''hands on'' aspects of training a patient how to inject insulin. For example, a telepresenter with a patient at the originating site (who is not a certified CDE) could assist with filling syringes, mixing doses, and showing the injection site location through illustration or pointing to areas on the body. Commenters also argue that the use of a large video monitor to show gradient markings on a syringe could be beneficial for patients with poor vision.

Response: As discussed in the proposed rule, we considered individual DSMT as a category 2 request because the components included in training a Medicare beneficiary to administer insulin injections are typically not part of the services currently on the list of telehealth services. We did not propose to add individual DSMT because the requestors did not submit any comparative analyses illustrating that the use of an interactive audio and video telecommunications system is an adequate substitute for individual DSMT furnished in-person.

Comment: Several commenters submitted summaries of studies and or articles regarding group psychiatry, individual psychotherapy, and medication management furnished as telehealth services. Additionally, an individual practitioner mentioned a study that compared diabetes education furnished through telemedicine with diabetes education furnished in-person.

Response: For category 2 services, we require evidence showing that the requested telehealth service is equivalent to the in-person delivery of the same service. The articles regarding mental health services and pharmacologic management do not address whether the use of a telecommunications system is an adequate substitute for the in-person delivery of MNT or DSMT. Additionally, individual psychotherapy and pharmacologic management are already on the list of Medicare telehealth services.

The comparison study regarding diabetes education focused on certain aspects of individual DSMT (but, as noted below, not on training patients to inject insulin), and therefore is irrelevant to the request to add group DSMT. The study conclusions mentioned that the ''diabetes nurse educator was even successful in

teaching insulin administration via telemedicine to a patient who had very high blood glucose levels''. However, training patients on the self-administration of injectable drugs (which typically occurs during an individual training session) was not the focus of this study and no conclusive evidence was provided showing that insulin administration can routinely be taught as a telehealth service.

Comment: Some commenters suggested that we approve the majority of DSMT for telehealth and require selected aspects of the training such as the instruction of insulin injections to be furnished in person by a CDE. For instance, one CDE stated that the use of telehealth would not be appropriate for teaching selected skills (such as the administration of self-injectable drugs, glucometer testing, or insulin pump therapy), and should not replace the initial assessment or all follow-up visits. Some CDE's and DSMT programs stated that a combination of in-person and telehealth training works well for their patients. However, commenters stated that the majority of the curriculum for an American Diabetes Association (ADA) recognized DSMT program can be successfully provided as a telehealth service. For instance, a CDE stated that curriculum components such as nutritional management, foot care, ketone testing, sick day management, use of a supplemental insulin scale, and treatment of hypoglycemia or hyperglycemia could be furnished as a telehealth service.

Response: DSMT is furnished either as an individual or group service as described by HCPCS codes G0108 and G0109 respectively. As many commenters mentioned, teaching a patient how to inject insulin is typically furnished as part of an individual DSMT session rather than in a group setting. Additionally, as discussed at § 410.141(c)(1), Medicare payment for initial DSMT may not exceed 10 hours of beneficiary training in which 9 hours of the training are usually furnished as a group service. Since teaching a patient how to inject insulin is typically an integral component of an individual training session, and comprises only 1 hour of a maximum of 10 hours of initial training, we do not believe that it would be appropriate to carve out selected skill-based training from an individual DSMT service.

We agree that skill-based training such as teaching patients how to inject insulin would be difficult to accomplish without the physical in-person presence of the teaching practitioner and believe this is not a common aspect of the current list of telehealth services. Given that teaching patients the skills required for insulin injection and blood glucose monitoring are typically furnished during an individual DSMT session we assigned the request to add individual DSMT to category 2. Moreover, as discussed previously, since the interactive dynamic of group DSMT is not similar to the current list of telehealth services, it does not meet the criteria for category 1. Therefore, we require evidence showing that the use of an interactive audio and video telecommunications system in furnishing DSMT is an adequate substitute for DSMT furnished in-person.

Comment: Some commenters believed that we compared group MNT to group psychiatric therapy or mental health counseling. The commenters suggest this is not a fair comparison because patients participating in a group MNT session typically do not discuss specific personal health information with the nutrition professional because the group ''therapy'' is a discussion of nutrition and is centered on a specific medical disease topic (for example, diabetes). Commenters contend that in the case of group MNT, the dietitian presents educational material to many beneficiaries at once and that the level of intense personal interaction found in group mental health services is not necessary in group MNT.

Response: As discussed previously, we compared the roles of, and interaction among, the beneficiary and physician (or other practitioner) in furnishing MNT and DSMT to the existing telehealth services. We did not compare group MNT to group psychiatric therapy or to group mental health counseling.

Comment: A few commenters stated that furnishing MNT for a diabetic patient is intended to be an adjunct to DSMT. For example, one group of commenters stated that without receiving DSMT, patients would not have an overall understanding of diabetes, how the disease develops and changes, and would not be taught additional methods for controlling glucose beyond those presented in MNT.

Response: Approving individual MNT for telehealth is one step along the way to helping more beneficiaries gain access to a collaborative skill-based DSMT program. As discussed earlier, we believe there should be conclusive evidence showing that DSMT can be as effective when furnished as a telehealth service as in a face-to-face encounter before we approve this service for telehealth.

Additionally, we conduct and sponsor a number of innovative demonstration projects to test and measure the effect of potential program changes. Our demonstrations study the likely impact of new methods of service delivery, coverage of new types of service, and new payment approaches on beneficiaries, providers, health plans, states, and the Medicare Trust Funds. We would encourage the commenters to take advantage of other programs that the agency has set up to increase medical quality and reduce cost. For more information on demonstration projects visit our web site at *www.cms.hhs.gov/researchers/demos.*

Comment: A few commenters requested that we pay for DSMT education provided to patients over the phone. One commenter submitted several studies and articles regarding telephone-based interventions for diabetes care, (for example, telephone counseling).

Response: Patient education provided over the phone is beyond the scope of this provision. Telephone calls do not meet the definition of an interactive telecommunications system and are not on the list of Medicare telehealth services. Additionally, as discussed in the Medicare benefits policy manual, publication 100–2, chapter 15, section 30, no separate payment is made for phone calls under the Medicare program.

Comment: One commenter requested us to recognize CDE's as a Medicare practitioner and allow them to bill the Medicare program directly.

Response: The statute does not permit a CDE to bill and receive direct payment for Medicare services. The statute defines a certified DSMT provider as a physician, other individual, or entity who, in addition to providing DSMT services, provides other items or services for which direct payment may be made. We do not have the statutory authority to establish a separate CDE benefit category.

Definition of an Interactive Telecommunications System

We received many comments regarding the use of an interactive audio and one-way video telecommunications system for delivering a Medicare telehealth consultation. Several commenters expressed qualified support for the use of an interactive audio and one-way video telecommunication for purposes of furnishing a telehealth consultation. For instance, some commenters believe that allowing one-way video would be appropriate in situations when it enables the consulting physician to add value to the

diagnosis and decision making capabilities of the patient care team at the originating site which includes, at a minimum, a treating physician; and where observation of the consulting physician by the patient is either unnecessary or not possible (for example, when the patient is unconscious).

Some commenters also suggested that we allow one-way video specifically for assessing suitability for stroke thrombolytic tissue-type plasminogen activator (tPA) therapy and compared the remote evaluation of a stroke patient for purposes of determining tPA treatment to a confirmatory consultation. For instance, the treating physician at the originating site would make a determination regarding the use of tPA and request a consultation to confirm his or her decision to use tPA therapy. Another commenter, who currently provides stroke consultation as a Medicare telehealth service, believes this service is an outpatient or inpatient consultation (where the neurologist at the distant site determines the treatment plan rather than offering a second or third opinion). The commenter also explained that they use an interactive audio and video telecommunications system that allows two-way real time video interaction between the consulting physician at the distant site and the originating site medical team.

One organization stated that payment should be made for physicians' services that are safe, effective, medically appropriate, and provided under accepted standards of medical practice. The commenter believes that the critical factor in determining whether to pay for a service should be medical necessity rather than the technology used to furnish the service. The commenter also compared the use of one-way video and two-way audio to a physician furnishing a visit to a blind patient. The commenter contends that we would not deny payment for a face-to-face consultation on the basis that the patient could not see the physician, and therefore we should not deny a telehealth consultation on the same basis.

Another commenter requested that we allow the use of one-way video equipment for delivering infectious disease telehealth consultations for ICU patients. The commenter explained that the hospital ICU is currently equipped with a one-way video, two-way audio telecommunications system and contends that moving interactive audio and video teleconferencing equipment to the ICU patient is very cumbersome and is only possible if appropriate technical staff are available.

We received a few comments regarding the added clinical value of two-way video versus one-way video and whether one-way video is appropriate for a broad range of specialty consultations. One commenter made the point that two-way video would allow the patient to see the physician or practitioner at the distant site when a greater degree of interaction is necessary. One organization believes that two-way video may add value to a telehealth consultation by allowing the patient and presenting practitioner (if necessary) to see the body language and other non-verbal communication of the physician or practitioner at the distant site. However, the commenter stated that payment should not be denied for using a one-way video telecommunications system. Another commenter supported using one-way video in limited emergent circumstances, but also stated that additional research should be conducted to determine whether the use of one-way video is appropriate for a broad range of specialty consultations.

Some commenters did not support the use of one-way video for furnishing a telehealth consultation. For instance, one commenter stated that face-to-face (interactive video) is a better method for obtaining patient compliance and results in a higher level of patient confidence with the health care team.

Response: We appreciate the comments on the use of an interactive audio and one-way video telecommunications system for purposes of furnishing a telehealth consultation. We intend to consider the suggestions raised by the commenters as we continue to evaluate conditions of payment for Medicare telehealth services. We continue to believe that the interaction between the consulting physician and the clinical staff at the originating site is important and it is not clear to us that one-way video is as effective in that regard as two-way video. With regard to the commenter who stated that the critical factor in determining whether to pay for a telehealth service should be based on medical necessity, we believe that the method used to furnish the service, for example the use of an appropriate telecommunications system, is just as critical as whether the service itself is medically necessary.

2. Definition of an Originating Site

As discussed in the August 8, 2005 proposed rule, section 418 of the MMA required the Health Resources Services Administration (HRSA) within HHS, in consultation with CMS, to conduct an evaluation of demonstration projects under which SNFs, as defined in section 1819(a) of the Act, are treated as originating sites for Medicare telehealth services. The MMA also required HRSA to submit a report to the Congress that would include recommendations on ''mechanisms to ensure that permitting a SNF to serve as an originating site for the use of telehealth services or any other service delivered via a telecommunications system does not serve as a substitute for in-person visits furnished by a physician, or for in-person visits furnished by a PA, NP or CNS, as is otherwise required by the Secretary.'' We indicated that this report was currently under development and that if the Secretary concludes in the report that it is advisable to include a SNF as a Medicare telehealth originating site under section 1834(m) of the Act, we would consider the recommendations of the report to determine whether to add SNFs to the list of approved originating sites. We also solicited comments on this topic.

Comment: We received many comments supporting the use of telehealth in a SNF. The commenters noted that adding a SNF to the definition of an originating site would provide increased access to specialty physicians and practitioners, most notably mental health services, and decrease unnecessary travel for both the beneficiary and nursing facility staff.

For example, one mental health practitioner stated that research studies indicate a critical shortage of psychiatrists in non-MSA areas and a lack of appropriate mental health care in rural SNF's as compared to their urban counterparts. As such, the commenter believes that many rural SNFs do not provide professional psychiatric or mental health care and that telehealth is one method that could be used to meet the mental health needs of the rural SNF population. Furthermore, the commenter stated that the lack of appropriate mental health care results in higher rates of psychiatric hospitalizations and the inability to effectively manage medications.

Another commenter believes that allowing telehealth services to be furnished in a SNF would increase access to follow-up care and would result in cost savings. For example, the commenter contends that addressing acute medical conditions earlier before they develop into a crisis could save money by reducing transportation costs and decrease the number of hospital admissions. The commenter also mentioned that traveling and waiting in an unfamiliar waiting room is often

confusing and uncomfortable for the patient. The use of telehealth for SNF residents could result in less travel hardships for both the patient and SNF staff.

Response: We appreciate the comments regarding the addition of SNFs to the definition of an originating site. At this time the telehealth report to the Congress, as required by section 418 of the MMA, is under development within HHS. As discussed previously, we have the authority to approve telehealth furnished in a SNF if the Secretary concludes in the report that it is advisable to include a SNF as a Medicare telehealth originating site under section 1834(m) of the Act.

Comment: A few commenters requested us to add other facilities in addition to a SNF to the definition of an originating site. For example, one organization requested that we expand the definition of an originating site to include domiciliary care facilities and other congregate-living arrangements if SNFs are approved as an originating site. Another commenter requested that we expand the definition of an originating site to allow all community hospitals regardless of their location (for purposes of furnishing a telehealth consultation for stroke patients). The commenter noted that a timely evaluation of a stroke patient is crucial for effective stroke treatment and argued that beyond three hours after onset, resuscitation of injured brain cells becomes increasingly unlikely. The commenter contends that timely access to a critical care neurologist remains a concern for the majority of community hospitals. Moreover, a national society of nephrology requested that we add a dialysis facility to the list of originating sites.

Response: The statute defines an originating site facility as a physician's or practitioner's office, hospital, critical access hospital, rural health clinic, or FQHC. Additionally, the statute only permits telehealth services to be furnished at an originating site located in a rural health professional shortage area as defined in section 332(a)(1)(A) of the Public Health Service Act or within a county that is not included in a metropolitan statistical area. We do not have the legislative authority (except for SNFs as indicated previously) to expand the definition of an originating site facility or to allow telehealth services to be furnished in a hospital regardless of geographic location.

3. Other Issues

Comment: One association urged us to pay for asynchronous ''store and forward'' dermatology consultations. The commenter explained that a store and forward consultation involves the transmission of dermatological photographs and other medical information to the consulting practitioner without interaction between the patient and practitioner at the distant site; the patient is not present for the consultation. The commenter contends that store and forward consultation is more convenient for the patient, originating site and consulting physician.

Response: Medicare telehealth services include office and other outpatient visits (99201 through 99215), professional consultations (99241 through 99275), individual psychotherapy (90804 through 90809), pharmacologic management (90862), psychiatric diagnostic interview examination (90801), and ESRD-related services included in the MCP (except for one visit per month to examine the access site). As a condition of payment under Medicare, these services require an in-person patient encounter. We believe that the patient's presence, and the use of an interactive audio and video telecommunications system permitting the distant site practitioner to interact with the patient, provides a reasonable substitute for an in-person encounter. The statute provides for the use of asynchronous, store and forward technologies for delivering telehealth services only for Federal telemedicine demonstration programs conducted in Alaska or Hawaii. We do not have the authority to expand the use of store and forward technology in delivering telehealth services.

Comment: Two commenters urged us to consider adding speech-language pathologist and audiologists as practitioners allowed to furnish and receive payment for telehealth services and noted that we have not submitted the telehealth report to the Congress on additional sites, geographic areas and practitioners that may be appropriate for Medicare telehealth payment. The commenters also mentioned that the American Speech-Hearing Association (ASHA) previously submitted a request for consideration in the CY 2005 physician rule to add various speech and audiology services to the list of Medicare telehealth services. The commenters believe that we have not responded specifically to ASHA's request to approve speech and audiology services for telehealth.

Response: The report to the Congress (as required by section 223(d) of the Medicare, Medicaid and State Child Health Insurance Program Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106–554)) on additional sites and settings, practitioners, and geographic areas that may be appropriate for Medicare telehealth payment is under development. We are considering the suggestions raised by the commenter as we formulate our recommendations to the Congress. Moreover, since speech language pathologists and audiologists are not permitted under current law to provide and receive payment for Medicare telehealth services at the distant site, we can not fully consider ASHA's request to add speech and audiology services to the list of Medicare telehealth services.

Comment: One commenter requested that we replace the term face-to-face with ''in-person''. The commenter believes that the term ''in-person'' is a better description of an encounter where the patient and practitioner are in the physical presence of each other.

Response: The commenter's suggestion to use the term ''in-person'' to describe an encounter where the physician or practitioner and the beneficiary are physically in the same room has been noted. We will consider the commenter's suggestion as we discuss Medicare telehealth payment policy.

Result of Evaluation of Comments

We will add individual MNT as represented by HCPCS codes G0270, 97802 and 97803 to the list of Medicare telehealth services. We also will add individual MNT to the list of Medicare telehealth services at § 410.78 and § 414.65. Moreover, since a certified registered dietitian or other nutrition professional are the only practitioners permitted by statute to furnish MNT, we will revise § 410.78 to add a registered dietitian and nutrition professional as defined in § 410.134 to the list of practitioners that may furnish and receive payment for a telehealth service.

E. Contractor Pricing of Unlisted Therapy Modalities and Procedures

We recognize that there may be services or procedures performed that have no specific CPT codes assigned. In these situations, it is appropriate to use one of the CPT codes designated for reporting unlisted procedures. These unlisted codes do not typically have RVUs assigned to them.

For services coded using these unlisted codes, the provider includes a description of the specific procedure(s) that was furnished. The contractor uses this information to determine an appropriate valuation.

As explained in the August 8, 2005 PFS proposed rule (70 FR 45788), currently, there are two unlisted CPT

codes with assigned RVUs, CPT 97039, *Unlisted modality (specify and time if constant attendance),* and 97139 *Unlisted therapeutic procedure.*

To make the pricing methodology consistent with our policy for other unlisted services, and to more appropriately match payments with the actual resources expended to deliver the services provided, we proposed to have our contractors value CPT codes 97039 and 97139.

We received several comments on this proposal and provide the following summary of the comments and our response below.

Comment: Two commenters were opposed to the proposal. These commenters stated they were concerned that contractor pricing would create inconsistencies in the payment for these services or would lower payment resulting in the services no longer being provided, potentially increasing the administrative burden and resulting in delayed payments. One of these commenters suggested that we work with interested specialties to better understand the services billed under these codes. Another commenter expressed concern that obtaining new CPT codes requires a good deal of research and investigation to ensure accurate payment.

Other commenters supported this proposed change, indicating that because these codes are used for widely different services they should be evaluated separately and there is no basis for assigning the code a set fee schedule rate.

Response: While it is true that having these codes priced by the contractors may result in some increase in administrative burden and impact the timeliness of payments, it will not necessarily result in lower payments. Our goal is to ensure appropriate payment for the actual services provided and we believe that our contractors will work with the provider community to make certain that this occurs. To the extent that providers believe that new codes are needed they might want to work with the specialty organizations to achieve this objective.

Final Decision: We are finalizing our proposal and our contractors will value CPT codes 97039 and 97139. We are assigning a status indicator of ''C'' to these two CPT codes.

F. Payment for Teaching Anesthesiologists

In the August 8, 2005 PFS proposed rule (70 FR 45789), we summarized the current policy for the payment for services provided by teaching anesthesiologists, including the revisions to the policy published November 7, 2003 (68 FR 63196 through 63395), where we revised § 414.46 of our regulations to allow teaching anesthesiologists to bill in a similar manner to teaching certified registered nurse anesthetists (CRNAs) for the teaching anesthesiologist's involvement in two concurrent cases involving residents. This policy took effect for services furnished on or after January 1, 2004 and was intended as an alternative to the ''medical direction'' payment policy applicable to concurrent cases involving teaching anesthesiologists and residents.

As noted in the August 8, 2005 proposed rule, despite the higher level of payment available under this policy, the American Society of Anesthesiologists (ASA) has informed us that it is not aware of any teaching anesthesia programs that have arranged their practices to meet the conditions necessary to bill under the revised policy. The ASA suggests that the teaching physician regulations for teaching anesthesiologists should be similar to those for teaching surgeons for overlapping complex surgery procedures. The ASA thinks that anesthesia is similar to complex surgery in terms of critical periods, overlap, and availability of teaching physicians. However, as we noted in the August 8, 2005 proposed rule, the critical portions of the teaching anesthesia service and the critical portions of the teaching surgeon service are not the same. The ASA believes that inadequate payment levels have contributed to the loss of teaching anesthesiologists and an inability to recruit new faculty.

In the August 8, 2005 proposed rule, we requested comments on a teaching physician policy for anesthesiologists that could build on the policy announced in the November 7, 2003 PFS final rule, but could provide the appropriate revisions that would allow it to be more flexible for teaching anesthesia programs. We also indicated we would be interested in receiving data and studies relevant to this issue as well as any offsetting savings that could be made to account for any potential costs that could be incurred if there was a policy change.

Discussion of Comments Received

As discussed previously in this section, we did not present a formal proposal, but asked for comments from interested stakeholders on these issues. While we have not fully analyzed all the relevant information and data, we have been provided anecdotal evidence that some anesthesiologists may be leaving academic practice for better compensated positions in private practice. While we recognize that Medicare payment policies are an important consideration in these decisions, they are not the only factor.

In contrast, as pointed out by a commenter, there has been an increase in the number of nurse anesthesia programs from 83 programs in 2000 to 105 programs projected for 2006. The number of nurse anesthesia graduates has surged from 1075 nurse anesthetists in 2000 to 2035 projected for 2006. Despite these increases, nurse anesthesia programs had reported similar financial problems, such as levels of teachers' salaries, in recruiting faculty to teaching nurse anesthetists.

In terms of anesthesia manpower, we did not receive any information from surgical groups indicating difficulty in getting anesthesiologists or CRNAs to provide anesthesia services. Additionally, we did not receive any comments identifying areas of offsetting savings that might be used to fund any change in the teaching anesthesia payment policy.

We will continue to review the information and relevant data presented by the commenters and consult with the stakeholders before we move forward with any proposal.

G. End Stage Renal Disease (ESRD) Related Provisions

On August 8, 2005, we published the Revisions to Payment Policies Under the Physician Fee Schedule for CY 2006 proposed rule in the **Federal Register** (70 FR 45789), revising payments to ESRD facilities under the provisions of the MMA. The proposed rule implements section 1881(b) of the Act, as amended by section 623 of the MMA, which directs the Secretary to make a number of revisions to the composite rate payment system, as well as payment for separately billable drugs furnished by ESRD facilities.

Under section 1881(b)(12) of the Act, the add-on adjustment must reflect both the effect of the new payment methodology and estimate growth in ESRD drug expenditures. We proposed an add-on adjustment of 8.1 percent to the composite payment rate to account for the difference between previous payments for separately billed drugs and biologicals and the revised pricing that will take effect January 1, 2006.

We updated that add-on adjustment to reflect estimated growth in ESRD drug expenditures of 0.7 percent. We combined the add-on adjustment of 8.1 percent that reflects the payment methodology we will be using for ESRD drugs with the 0.7 percent increase for expenditures in 2006 to produce one

proposed drug add-on adjustment for CY 2006 of 8.9 percent.

Following publication of the proposed rule, it came to our attention that 3 codes had been omitted in our analysis of drug payments and utilization for the top ten ESRD drugs that affected our calculation of the proposed add-on adjustment. On September 1, 2005, we issued a correction notice on the CMS Web site, to correct our omission of the 3 J Codes in the estimation of the market shares for the top ten ESRD drugs used in our calculation of the proposed drug add-on adjustment for 2006. The ''Correction to the Proposed ESRD Drug Add-on Adjustment: Revised Table 22'' is available at *http://www.cms.hhs.gov/providers/esrd/090105_ESRD_Correction.pdf.* The corrected table shows the revised weights compared to the weights included in the proposed rule and resulted in a revised proposed total drug add-on adjustment to the composite payment rate of 11.3 percent for 2006.

We also proposed to revise the drug pricing for ESRD drugs to ASP+6 percent for the top ten drugs furnished by independent facilities and EPO furnished by hospital-based facilities.

In addition, section 1881(b)(12) of the Act as amended by section 623 of the MMA provided authority to the Secretary to revise the geographic index applied to the composite payment rate and phase in any changes to the index over a multi-year period. Accordingly, we proposed to revise the geographic classifications and wage indexes currently in effect for adjusting composite rate payments and to implement these changes over a 2-year transition period.

We also proposed to revise the regulations applicable to the composite rate exceptions process to reflect section 623 of the MMA provisions that restricts exceptions to pediatric facilities.

No changes to the current case-mix adjustments were proposed.

We received a total of 37 comments from the ESRD community that represented major organizations, pharmaceutical companies, beneficiaries, and concerned individuals. The comments and responses are summarized in the following sections.

1. Revised Pricing Methodology for Separately Billable Drugs and Biologicals Furnished by ESRD Facilities

In the August 8, 2005 proposed rule, we proposed that payment for drugs furnished in connection with renal dialysis services and separately billed by independent renal dialysis facilities would be based on payment amounts determined under section 1847A of the Act which are 106 percent of the ASP. We proposed to update the payment allowances quarterly, based on the ASP reported to us by drug manufacturers. We also proposed to pay for EPO in hospital-based facilities at the ASP+6 percent. We stated that we are interested in moving to the ASP+6 percent methodology for all separately billed drugs and solicited comments on a drug add-on estimation methodology that would allow us pay hospital-based facilities ASP+6 percent for all separately billable drugs.

In this final rule with comment, we are implementing payment of ASP+6 percent for all ESRD drugs furnished by both independent and hospital-based ESRD facilities. A discussion of the final drug payment methodology and related comments and responses can be found in section II.H.2.

2. Adjustment to Account for Changes in the Pricing of Separately Billable Drugs and Biologicals, and the Estimated Increase in Expenditures for Drugs and Biologicals

Section 1881(b)(12) of the Act, as added by section 623(d) of the MMA, contains two provisions that describe how the drug add-on adjustment will be implemented in the ESRD payment system. First, the add-on adjustment must reflect the difference between the payment methodology for separately billed drugs under the drug price in effect in CY 2004 and current drug pricing and, second, the aggregate payments for CY 2005 must equal aggregate payments absent this MMA provision.

Prior to 2005, separately billable ESRD drugs and biologicals other than EPO furnished in independent facilities were paid under the average wholesale price (AWP) methodology. In 2005, section 1881(b)(13)(A)(ii) of the Act required that we pay the acquisition cost for separately billable ESRD drugs (including EPO) as determined by the Office of the Inspector General (OIG). If the OIG did not determine an acquisition cost for a separately billable drug or biological, then the Secretary was given discretion to determine the payment rate. In the CY 2005 final rule (69 FR 66322–66323), we described the methodology that we used for developing the drug add-on adjustment to the composite rate to account for the difference between estimated drug payments under the AWP payment system and the acquisition costs as determined by the OIG. This adjustment was developed so that aggregate spending for composite rates plus separately billed drugs would remain budget neutral for CY 2005.

Section 1881(b)(12) of the Act, as added by section 623 (d) of the MMA, also contains two provisions related to adjustments to payments for drugs and biologicals for CY 2006. Section 1881(b)(12)(C)(ii) of the Act requires that we recalculate the 2005 add-on adjustment to reflect the difference between estimated payments using the AWP payment methodology and the payment methodology for 2006 which we proposed to be ASP+6 percent.

In addition, section 1881(b)(12)(F) of the Act requires that, beginning in 2006, we establish an annual update adjustment to reflect estimated growth in expenditures for separately billable drugs and biologicals furnished by ESRD facilities. This update would be applied only to the drug add-on portion of the composite payment rate. In order to meet both requirements, we proposed to develop the CY 2006 drug add-on adjustment in two steps.

First, we proposed to recalculate the CY 2005 add-on adjustment to reflect the difference in drug payments using 95 percent AWP pricing and payments using ASP+6 pricing. The result of this calculation would replace the current 8.7 percent adjustment and would be budget neutral to CY 2005 payments. Next, we proposed to develop a proposed annual update methodology that we would first use in CY 2006 to reflect the estimated growth in drug expenditures each year. As stated previously, this update would be applied only to the drug add-on portion of the composite payment rate. For specific details regarding the proposed adjustments, see the August 8, 2005 **Federal Register** (70 FR 45793 through 45800).

As noted previously, we issued a correction to the proposed ESRD drug add-on adjustment contained in the proposed rule. In this notice we acknowledged that our estimation of the market shares for the top ten ESRD drugs that we used in the calculation of the proposed drug add-on for 2006 was incorrect. After further analysis of the 2003 expenditure data used to assign weights to the top ten ESRD drugs, we determined that our data did not account for 3 new ''J'' codes that were implemented in 2003. As a result, the weights for Iron Sucrose, Sodium Ferric Gluconate and Paricalcitol were understated.

In addition, we noted that the weight for EPO incorrectly included expenditures for hospital-based facilities. Since the purpose of the weighting was to allocate the drug spread to all other drugs paid using the

proposed ASP+6 percent pricing, hospital-based data should not have been included because we paid for other hospital-based drugs based on cost. Table 16 shows the revised weights compared to the weights included in the proposed rule.

TABLE 16.—REVISED TO REFLECT CORRECTION

Drugs	Published proposed weights	Revised proposed weights
Epogen	78.83	69.33
Calcitriol	0.13	0.84
Doxercalciferol	1.74	1.48
Iron dextran	0.38	0.23
Iron sucrose	0.71	7.03
Levocarnitine	0.89	0.77
Paricalcitol	17.37	14.61
Sodium ferric glut	0.53	4.96
Alteplase, Recombinant	0.18	0.56
Vancomycin	0.24	0.19

We note that as a result of these data corrections, the top ten drugs account for 98 percent of total ESRD drug expenditures, rather than 92 percent as stated in the proposed rule.

Using these revised weights, the proposed recalculated 2005 drug add-on adjustment was corrected to 10.4 percent, and the proposed 2006 update was corrected to 0.8 percent. The corrected total drug add-on adjustment proposed for 2006 was 11.3 percent.

The proposed rule also discussed a method to estimate the drug spread applicable to hospital-based facilities for non-EPO drugs if we decided to implement ASP+6 percent pricing for all hospital-based drugs. This methodology would use the weighted average drug spread percent for independent facilities to estimate the drug spread for non-EPO drugs furnished by hospital-based ESRD facilities.

The following sections discuss the comments we received on these issues and provide a detailed description of the final drug add-on adjustment to the ESRD composite payment rate that will be implemented January 1, 2006.

Comment: We received a number of comments advocating that drug payments to hospital based facilities should be the same as to independent facilities. However, most of these comments raised no concerns regarding our proposed methodology for computing the drug spread applicable to hospital-based facilities. Two comments specifically supported our proposal to use the drug pricing drug spread from independent facilities to estimate the spread for hospital-based facilities. Two comments stated we should follow MedPAC's suggestion that we collect data to estimate hospital-based facilities' cost and Medicare payment per unit for ESRD drugs, but did not raise concerns with our proposed alternative method for estimating the drug spread applicable to hospital-based facilities if we implemented ASP+6 percent pricing. MedPAC recommended that we use the same methodology to pay for all drugs (regardless of setting) and suggested that we could use dosing data from independent facilities to estimate ASP+6 payments for hospital-based facilities to compute the drug spread related to hospital-based facility drug payments.

Response: Given both the MedPAC recommendation that ASP should be the basis of payment for all separately billable ESRD drugs and the overall support for providing consistent drug payments for both hospital-based and independent facilities, we have decided, in light of section 1881(b)(13)(A)(iii) of the Act, to implement ASP+6 percent pricing for hospital-based facilities beginning January 1, 2006. See section II.H.2 for a more detailed discussion of this issue. We are adopting the methodology outlined in the proposed rule to determine the drug spread applicable to hospital-based facilities and to calculate a drug add-on adjustment. We are also adopting the proposed methodology which would permit us to implement a change in payment to ASP+6 percent for all non-EPO drugs provided by hospital-based ESRD facilities.

While we agree that the ideal approach would be to collect data from hospital-based facilities, this data collection would significantly delay implementation of a consistent ESRD drug payment policy. Absent the collection of data, we believe that using the estimation methodology described in the proposed rule brings us closer to the actual price of hospital drugs (ASP+6 percent) than does the policy of continuing to rely on reasonable costs.

In response to MedPAC's suggestion, we did an analysis of drug dosing units from the billing data of independent facilities and were unable to determine accurate monthly average units from those bills, because facilities do not bill individual line items by date of service. As a result, the average monthly dose we computed for some drugs was significantly below the FDA expected monthly dose. In other words, the average monthly dose for the top ten ESRD drugs from independent facility data that we could use as a proxy for pricing the hospital-based bills was problematic. We believe the statute contemplates a single payment approach for separately billable ESRD drugs. Therefore, using our estimation proposal is a start towards MedPAC's principle that the same prices should be paid for the same services across all settings which we believe is consistent with the statute. Furthermore, moving to ASP+6 percent pricing for hospital-based facilities evens out the effect of the drug add-on adjustment between independent and hospital-based facilities.

Therefore, we have computed the drug spread for non-EPO hospital based drugs using the weighted average drug spread percentage from independent facilities. We applied that percentage to the total hospital-based drug payments in order to estimate the amount of the drug spread as a result of revising the drug pricing methodology to ASP+6 percent for hospital-based facilities.

We believe this method provides a reasonable estimation of the drug spread because, as explained previously, all drugs in both settings are based on ASP+6 pricing. Moreover, we believe that the benefits of implementing a consistent drug payment methodology outweighs any potential drawbacks that may result from estimating the drug spread without more precise data. We intend to pursue options for obtaining additional data to more accurately

compute and update the drug add-on adjustment. Once more complete hospital-based ESRD drug data become available, we will re-examine the computation of the drug add-on adjustment and make any necessary revisions to our estimations.

Comment: We received comments from two associations representing ESRD facilities that expressed concern about our interpretation of the statutory provision related to the drug add-on adjustment. These comments presented legal arguments challenging our decision to apply a single drug add-on adjustment that is applicable to both hospital-based and independent ESRD facilities. Both comments indicated that as long as separate drug payment methodologies are in place for hospital-based facilities and independent facilities, the statutory text, structure, and legislative history requires that we establish distinct drug add-on adjustments. Another commenter recommended that the add-on adjustment should be directly linked to hospital-based and independent facilities based on the actual loss of revenue due to changes in reimbursement for separately billed drugs.

Response: We continue to believe that our interpretation of this statutory provision represents the best reading of the statute as we explained, for reasons, discussed, in the CY 2005 final rule (see 69 FR 66319 through 66320). Accordingly, rather than adopting separate add-on adjustments for independent and hospital-based ESRD facilities, we are addressing the payment inequities expressed in the comments and pointed out in the MedPAC report that result from differential drug payment methodologies for hospital-based and independent facilities. As discussed previously, we are implementing a consistent drug payment methodology for all ESRD provider settings. In this way, we believe we have resolved the concerns expressed by these commenters in a manner consistent with the statute.

a. Recalculation of the CY 2005 Drug Add-on Adjustment

For CY 2006, we proposed to use the same method that we used to develop the drug add-on adjustment for CY 2005 to recalculate the 2005 adjustment to reflect the proposed revision to the ESRD drug payment methodology from acquisition costs to ASP+6 percent. That is, we proposed to calculate the spread based on the difference in aggregate payments between estimated payment based on AWP pricing and estimated payment based on ASP+6 pricing. Although we proposed to use pricing data from the second quarter of CY 2005, we indicated that all of the data used to develop the proposed add-on adjustment would be updated for the final rule with comment, as more current data would be available.

(1) Historical Drug Expenditure Data

To develop the drug add-on adjustment for this final rule with comment, we used historical total aggregate payments for separately billed ESRD drugs for calendar years 2001, 2002, 2003, and 2004. For EPO, these payments were broken down according to type of ESRD facility (hospital-based versus independent). We also used the number of dialysis treatments performed by these two types of facilities over the same period.

(2) ASP+6 Percent Prices

In the proposed rule we used the ASP+6 percent prices for the second quarter of CY 2005. However, we indicated that we would use all four quarters of CY 2005 prices to develop the CY 2005 ASP payments.

Comment: One commenter raised concerns regarding using four quarters of the ASP to determine an annual average. This commenter indicated that the most recent available quarter, specifically, the fourth quarter ASP prices of any CY represents the ASP for the entire year. This commenter recommended that, instead of using all four quarter of CY 2005, we use only the fourth quarter of CY 2005 ASP to calculate the difference in the aggregate payments based on 95 percent AWP pricing and the estimated payment based on ASP+6 percent.

Response: We do not agree with this recommendation and have used the average of ASP prices in all four quarters of 2005 to calculate the add-on adjustment. The fourth quarter of the ASP represents only the most current ASP prices, and does not represent an aggregate annual average. Therefore, our calculation for ASP+6 percent includes not only the most current quarter (that is, the fourth quarter ASP) but also the previous three quarters of ASP pricing data for 2005). We believe this calculation provides the most accurate estimation of 2005 actual ASP+6 percent payments.

We used four quarters of 2005 ASP+6 percent prices for the drugs listed in Table 17. We averaged these to develop prices representing the average 2005 ASP payments.

TABLE 17

Drug	Average sales price plus 6% 2005
Epogen	$9.30
Calcitriol	0.75
Doxercalciferol	2.19
Iron dextran	11.21
Iron sucrose	0.36
Levocarnitine	12.30
Paricalcitol	3.92
Sodium ferric glut	4.74
Alteplase, Recombinant	30.61
Vancomycin	2.95

(3) Estimated Medicare Payments Using 95 Percent of AWP

In the proposed rule, we used the first quarter 2005 AWP prices and updated them to the second quarter by applying, for drugs other than EPO, an estimated AWP quarterly growth of approximately 0.74 percent. In order to estimate AWP payments for this final rule with comment, we used 4 quarters of 2005 AWP prices and averaged them to obtain prices representative of 2005 payment amounts. This methodology was not applied to the price for Epogen since payment was maintained at $10.00 per thousand units prior to MMA (see Table 18).

TABLE 18

Drugs	2005 average estimated medicare payments using 95% of AWP
Epogen	$10.00
Calcitriol	1.36
Doxercalciferol	3.98
Iron dextran	17.91
Iron sucrose	0.65
Levocarnitine	36.48
Paricalcitol	5.32
Sodium ferric glut	8.17
Alteplase, Recombinant	31.89
Vancomycin	3.79

(4) Dialysis Treatments

In the proposed rule, using the most complete data available at the time, we estimated total dialysis treatments for 2005 at 34.5 million.

Comment: We received comments suggesting that our estimate of dialysis treatments was overstated.

Response: Using more recent data that has become available since we issued the proposed rule, we increased our projection of total number of dialysis treatments based on actuarially projected growth in the number of ESRD beneficiaries. Since Medicare covers a maximum of three treatments per week, utilization growth is limited, and, therefore, any increase in the number of

treatments should be due to beneficiary enrollment. The actual 2004 data we used in this final rule with comment, showed higher treatment counts than we had projected for 2004 in the proposed rule. Therefore, for CY 2005, we estimate there will be a total of 34.7 million treatments performed.

(5) Drug Payments

In the proposed rule, we updated drug payments for both EPO and non-EPO drugs using the estimated trend factor for EPO of 9.0 percent. We proposed using the EPO 9.0 percent trend factor for all drugs (not just for EPO) because EPO constitutes the largest proportion of drugs furnished by ESRD facilities and because we determined that the extremely varied growth in spending for non-EPO drugs between 2000 and 2003 prohibited a reliable trend analysis. As we indicated we would do in the proposed rule, we used later 2004 drug payment data for the final rule with comment and trended those data forward to 2005.

Comment: We received a number of comments concerning our use of the EPO trend factor to update drug payments to 2005. These comments expressed concern that this resulted in understating the growth in ESRD drug payments. We also received comments that we should correlate the growth of EPO and other separately billable ESRD drugs.

Response: Since we now have 2004 data, we have modified the trend factor to more accurately reflect the growth in drug payments. In addition, we have calculated trend factors for non-EPO drugs independently of those for EPO.

We updated the total aggregate EPO drug payments for both hospital-based and independent facilities by using historical trend factors using data from 2001 through 2004. For CY 2005, the CY 2004 payment level was increased by a trend factor of 11.0 percent.

Similarly, we updated the aggregate spending for separately billable drugs, other than EPO, for both hospital-based and independent facilities by using a historical trend factor of 15 percent.

In addition, we deducted 50 cents for each administration of EPO from the total EPO spending for both hospital-based and independent facilities to account for payment for syringes that were included in the EPO payments prior to the implementation of the MMA drug payment provisions.

In the proposed rule, we estimated the cost of syringes at $1.6 million for hospital-based facilities and $26.8 million for independent facilities.

Comment: We received comments that the proposed $26.8 million dollars estimated for syringe payments to independent facilities was too high, because the estimated number of administrations of EPO exceeded the number of treatments.

Response: We have re-estimated the syringe payments to take into account problems we encountered related to the administrations field on the dialysis bills. Thus for the final rule with comment, we are calculating syringe payments as 50 cents multiplied by 90 percent of estimated treatments for 2005. The 90 percent represents the percent of dialysis patients that receive EPO. Since we only pay for one administration per treatment we applied this 90 percent to total treatments in order to estimate the number of EPO administrations.

Using this methodology, for CY 2005, we estimate payments for these syringes will amount to $1.8 million for hospital-based facilities and $13.8 million for independent facilities.

For CY 2005, we estimate that total spending for separately billable drugs will reach $462 million for drugs provided in hospital-based facilities ($217 million for EPO and $245 million for other drugs), and $3.102 billion for drugs provided in independent facilities ($2.082 billion for EPO and $1.019 billion for other drugs).

Comment: One comment indicated that we were eliminating separate payments for syringes.

Response: We believe the commenter misunderstood our payment policy. We currently pay separately for syringes used to administer ESRD drugs, and will continue to do so. We began paying separately for the syringes associated with administration of EPO when EPO payment was revised from payment at $10 per 1,000 units in 2005. While the previous $10 payment included payment for syringes, the new payment methodology does not. We have not modified our approach to paying for syringes in general, but now also pay separately for syringes associated with the administration of EPO.

(6) Add-On Calculation and Budget Neutrality

In the August 8, 2005 proposed rule (70 FR 45789), we acknowledged a mistake in our calculation of the proposed drug add-on adjustment. The proposed 2005 recalculated add-on adjustment was 10.4 percent. In addition, we indicated in the proposed rule that we intended to include more recent 2004 billing data in the calculation of the final drug add-on adjustment.

Comment: We received a number of comments commending us for responding to industry concerns by making the corrections to the proposed add-on calculation and urging us to use the most accurate, up-to-date data and trends available to compute the 2005 budget-neutral add-on adjustment.

Response: We have taken these comments into consideration and have updated all of the data and assumptions used to calculate the add-on adjustment as described below.

For each of the top ten drugs, we calculated the percent by which ASP+6 percent is projected to be less than payment amounts under the 95 percent of AWP pricing system for 2005. We then calculated a weighted average of the percentages by which ASP+6 percent would be below 95 percent of AWP payment amounts, for the top 10 ESRD drugs for independent facilities. We weighted these percentages by using the 2005 estimated Medicare payment amounts for the top ten drugs. This procedure resulted in a weighted average payment difference of 16 percent.

TABLE 19

Drugs	2005 estimated medicare payment weights as a percentage of total drug expenditures	Percent by which ASP+6% prices are below 95% of AWP prices
Epogen	67.96	7.03
Calcitriol	0.45	44.74
Doxercalciferol	3.62	44.94
Iron dextran	0.11	37.40
Iron sucrose	7.79	44.50

TABLE 19—Continued

Drugs	2005 estimated medicare payment weights as a percentage of total drug expenditures	Percent by which ASP+6% prices are below 95% of AWP prices
Levocarnitine	1.11	66.27
Paricalcitol	13.38	26.44
Sodium ferric glut	4.64	41.96
Alteplase, Recombinant	0.75	4.00
Vancomycin	0.20	22.20

Since we estimate that these 10 drugs represent nearly 98 percent of total 2005 drug payments to both hospital-based and independent facilities, we applied the weighted average to 100 percent or all of aggregate drug spending projections for hospital-based and independent facilities, producing a projected difference of $585 million (the sum of $76 million for hospital-based and $509 for independent facilities). Since we do not currently have reliable data on dosing units from hospital-based bills, we believe it is reasonable, as discussed above, to proxy the drug spread for hospital-based facilities using the spread for independent facilities. The weighted average is applied to 100 percent of drug spending projections for hospital-based and independent facilities.

Distributing the total 2005 figure of $585 million over a total projected 34.7 million treatments results in a revised 2005 add-on to the per treatment composite rate of 13.1 percent. This compares to the proposed adjustment of 10.4 percent. By making this adjustment to the composite rate, we estimate that the aggregate payments to ESRD facilities would be budget neutral for drug payments for 2005, as required by the MMA. We note that, beginning January 1, 2006, this 13.1 percent adjustment replaces the 8.7 percent adjustment currently in effect for CY 2005.

b. Calculation of the Proposed CY 2006 Inflation Update to the Drug Add-On Adjustment

The proposed rule described the approach we proposed to use to update the drug add-on adjustment to account for the estimated growth in drug expenditures between 2005 and 2006. Based on the most recent, complete data that was available at the time, we proposed a 2006 inflation adjustment of 0.8 percent to the drug add-on to the composite payment to reflect the estimated growth in drug expenditures between 2005 and 2006. While we received no comments specific to the add-on inflation adjustment, we did receive comment about our growth projections used to calculate the adjustment. Those comments were addressed in the previous section.

(1) Drug Payments and Dialysis Treatments

Similar to the above mentioned process, we updated the total aggregate EPO drug spending for hospital-based and independent facilities using historical trend factors. For 2006, the EPO payment level was increased from 2005 by a trend factor of 11.0 percent. We also updated aggregate spending for separately billable drugs, other than EPO, for both hospital-based and independent facilities by a trend factor of 15 percent. This procedure resulted in projected drug expenditures of $523 million for drugs provided in hospital based facilities ($240 million for EPO and $283 million for other drugs) and $3.481 billion for drugs provided in independent facilities ($2.306 billion for EPO and $1.175 billion for other drugs). These numbers include an estimated reduction for the 50 cent payment for syringes of $1.9 million for hospital-based facilities and $14.1 million for independent facilities. We also updated the projected number of dialysis treatments using actuarial enrollment projections. This resulted in total of 35.6 million treatments for 2006.

(2) Adjustment to Composite Rate Add-On

The proposed computation of the 2006 inflation adjustment to the composite rate was 0.8 percent. We have updated our projected inflation adjustment for the drug add-on and have included data for non-EPO hospital-based drugs into the computation.

Since EPO is updated at an average trend of 11 percent and other separately billable drugs are updated by a trend factor of 15 percent, for both hospital-based and independent facilities, for 2006 we computed a combined weighted average growth in total drug expenditures of 12.3 percent, based on the relative proportions of EPO and non-EPO drugs. We then applied the 12.3 percent projected growth in aggregate drug expenditures between 2005 and 2006 to the 2005 drug add-on figure of $585 million. This resulted in a projected incremental increase in the drug spread for 2006 of $72 million ($9 million for drugs furnished by hospital-based facilities and $63 million for drugs furnished by independent facilities). We distributed the $72 million over 35.6 million projected treatments, resulting in a 1.4 percent increase to the 2005 composite payment rate.

Comment: We received a number of comments regarding an annual update factor. Several comments recommended that we should provide an annual update to the composite rate. The specific recommendation suggested an annual market basket update in the composite rate equivalent to the MedPAC recommendation of an increase to the composite payment rate of 2.5 percent in 2006. The comments further acknowledged that the creation of an annual market basket update requires Congressional action.

Response: Because Congressional action is required, there is no specific provision in the current statute or regulations for an annual update for the composite payment rate based on the ESRD market basket rate of increase. However, the statute does, in effect, provide for an annual update to the drug add-on to the composite payment rate. As discussed previously, the statute requires that we annually update the amount of the drug spread included in the composite payment rate, based on the projected growth in drug expenditure between 2005 and 2006. We are providing an inflation adjustment to the composite payment rate of 1.4 percent. Even though this inflation adjustment is part of the overall add-on adjustment, the overall effect for 2006 is equal to an update of 1.4 percent.

In addition, we note that as part of our work on the development of a fully bundled prospective payment system (PPS) for ESRD facilities, we will be developing an update framework that would include an ESRD market basket factor. We expect to include a discussion of this update framework as part of a Report to Congress on a fully bundled PPS for outpatient ESRD facilities. This report is still under development.

Comment: One comment stated that the add-on adjustment to the composite rate should be reflected as an absolute dollar amount rather than a percentage, stating that there is no logical reason why the drug add-on component should be adjusted by a wage index.

Response: Section 1881(b)(12)(A) of the Act which was added by the MMA, required the establishment of a ''case-mix adjusted prospective payment system for dialysis services'' that included: (1) The composite rate; (2) case-mix adjustment for a limited number of patient characteristics; and (3) a drug add-on adjustment to the composite rate to account for the difference in drug payments compared to the previous drug pricing methodology. Section 1881(b)(12)(D) requires that payments under this system be adjusted by a geographic index. Therefore, we are required to apply the wage index to all components of the case-mix adjusted composite rate system.

c. Drug Add-On Adjustment for 2006

With the CY 2005 add-on to the per treatment composite rate being 13.1 percent and the additional increment for expenditures in CY 2006 being 1.4 percent, the combined drug add-on adjustment for 2006 is 14.7 percent (1.131×1.014).

3. Revisions to Geographic Designations and Wage Indexes Applied to the ESRD Composite Payment Rate

Section 1881(b)(12)(D) of the Act, as added by section 623(d) of the MMA, gave the Secretary the discretionary authority to revise the current wage index incorporated in the ESRD composite payment rates. That provision also requires that any revised wage index be phased in over a multiyear period. We proposed to adopt OMB's revised geographic definitions (announced in OMB Bulletin No. 03–04, issued June 6, 2003) to determine urban and rural locales for purposes of calculating ESRD composite payment rates, beginning January 1, 2006. In conjunction with using OMB's geographic designations, we proposed to recalculate the ESRD wage index based on acute care hospital wage and employment data for FY 2002, as reported to us in connection with development of the wage index used in the inpatient hospital prospective payment system (IPPS). We also proposed to update the labor portion of the ESRD composite rate to which the wage index is applied. Below we discuss comments we received on these proposals and our final determinations regarding CY 2006 revisions to the wage index adjustment as it is applied to the ESRD composite payment rate.

a. Use of Revised OMB Geographic Area Designations To Determine Urban and Rural Locales for ESRD Composite Payment Rates

In the August 8, 2005 proposed rule, we proposed to use OMB's revised core-based statistical area (CBSA)-based definitions for Metropolitan Statistical Areas, New England County Metropolitan Areas, and Micropolitan Statistical Areas, announced in OMB Bulletin 03–04 (June 6, 2003) as the basis for revising the urban/rural locales and corresponding wage index values reflected in the composite payment rates. The definitions we proposed are the same urban and rural definitions used for the Medicare IPPS, but without regard to geographic reclassifications authorized under section 1886(d)(8) and (d)(10) of the Act. In conjunction with adopting OMB's geographic classifications, we proposed replacing the current weighted wage index based on a 60/40 blend of Bureau of Labor Statistics (BLS) and hospital wage index values with one developed exclusively from acute care hospital wage and employment data obtained from the Medicare hospital cost reports. We proposed to update the wage index annually. For a full discussion of our proposals, see the August 8, 2005 proposed rule (70 FR 45793 through 45800). The following section contains a summary of the comments that we received on the proposed wage index revisions.

Comment: Several commenters, generally those representing independent ESRD facilities located in rural areas, opposed implementation of the CBSA based wage index. The commenters expressed concern that the proposed wage index would jeopardize beneficiary access to care, and left little protection for rural facilities. Some commenters pointed out the amount of the reduction in composite payments that specific providers would incur based on the proposed urban/rural definitions and revised wage index values.

Response: The current urban/rural definitions reflected in the composite payment rates have been in effect for over 20 years, and needed to be updated. By revising those definitions to conform with the latest available OMB geographic designations as explained in the August 8, 2005 proposed rule, we believe that we are complying with the express intent of the Congress permitting revision of those designations, as set forth in section 1881(b)(12)(D) of the Act. While our authority to revise the current ESRD wage index is discretionary, we believe this revision is essential if the composite rates are to reflect accurately the costs of providing ESRD services.

None of the commenters proposed an alternative to our proposed geographic classification system. Because we must have a national classification system built on clear objective standards, we are adopting the CBSA based urban/rural definitions, as described in our proposed rule. As to commenters' concerns about any reductions in the base composite payment rates, we have taken these concerns into consideration and have adopted a transition policy concerning the wage index. We address commenter's comments and provide a more detailed discussion of our transition policy in section II.3.c. of this final rule with comment.

Comment: While several commenters supported the implementation of the new CBSA based wage index, they expressed concern over the potential impact on independent ESRD facilities, particularly those located in rural areas. The most frequent recommendations to reduce the impact of any payment reductions were to extend the proposed transition period from 2 to 5 years, and provide annual updates of the wage index in each of those years.

Response: We agree that the new CBSA based wage index should be revised periodically to account for not only changes in labor market conditions, but also any future revisions in the definitions of the Metropolitan Statistical Areas and other geographic designations which may be announced by OMB. We will revise the ESRD wage index annually using the most recent Medicare cost report data as is used in the Medicare hospital IPPS. We also agree that the proposed transition period of 2 years may not be sufficiently long to provide ESRD facilities with enough time to adapt to the new wage index and have extended the transition period to 4 years. For a more complete discussion of our policies to help ESRD facilities adapt to the OMB geographic designations and wage index revisions

we have adopted for ESRD purposes (see section C of this preamble).

Comment: Several commenters endorsed our adoption of the proposed wage index based on the revised OMB definitions. However, the commenters were critical of what they perceived to be a lack of transparency in the data and methodology used to develop the new wage index, especially the budget neutrality adjustment. The commenters requested that we provide the data and methodology used to calculate the new wage index values and BNF.

Response: For purposes of adjusting the labor-related portion of the CY 2006 ESRD composite rate, we are using the most recent hospital wage data applicable to FY 2006 payments as discussed previously in this section. We start with the wage index used by the Skilled Nursing Home Prospective Payment System (SNF PPS) and multiply this index by a numeric factor, which is the budget neutrality adjustment. We use the SNF PPS wage index because we believe it reflects the most recent data, and is consistent with all other non-acute care facility payment systems.

As explained earlier in this section, we begin with the same wage index values as those used by the SNF and multiply those values by the BNF (See Tables 21 and 22). The methodology for creating this wage index BNF is explained in further detail below.

The wage index measures relative differences in the average hourly wage for the hospitals in each labor market area compared to the national average hourly wage. As stated previously, for ESRD payment purposes the wage index values are based on wage data as reported by hospitals on their Medicare cost reports. The wage data used to construct the wage index are updated annually, based on the most current data available. Accordingly, 2002 wage data were used to construct the wage index values used in this final rule with comment and 2003 wage data will be used to construct the wage index that we intend to use for the ESRD composite rate for CY 2007.

For each geographic area, wage data for all providers in that area are combined. The sum of all wages for all providers in that geographic area is divided by the total hours for all providers in that geographic area. The result is the average hourly rate for that geographic area. This data can be found at the following link: *http://www.cms.hhs.gov/providers/hipps/ippswage.asp.*

The data will be found under the section labeled, ''FY 2006 Wage Index Public Use Files'', and contains average hourly rate data and wage index. The index is computed by dividing the average hourly rate for each geographic area within the CBSA by the national average hourly wage.

As we noted earlier, for the ESRD wage index we are using hospital wage data without regard to any approved geographic reclassification authorized under sections 1886(d)(8) and (d)(10) of the Act or other provision that only applies to hospitals paid under the IPPS. For purposes of the ESRD wage index methodology, the data we use is pre-reclassified, pre-floor hospital data and unadjusted by occupational mix.

The final step is to multiply each wage index value by the wage index budget neutrality factor (BNF) (see section 4 for details about this adjustment).

Comment: One commenter strongly objected to our proposed implementation of the CBSA based wage index. The commenter maintained that we have failed to examine the entire dialysis patient delivery system taken as a whole. Specifically, we have not recognized that rural facilities generally have lower utilization, and consequently higher costs per treatment, especially for overhead and supplies, compared to urban facilities. The commenter offered three options for consideration-the establishment of one composite rate for all dialysis facilities, the creation of a special composite rate adjustment factor that compensates rural facilities for their higher overhead costs due to lower utilization, or the creation of an explicit exception for higher rural facility overhead costs.

Response: We recognize that large chain dialysis providers operate with the benefit of economies of scale, and may be better able to adapt to the impact of policy changes to the composite payment rates. However, we have no evidence to indicate that rural facilities have higher overhead and supply costs per treatment. Payments to rural facilities are lower compared to urban facilities because rural facility composite rate costs, including labor costs, are generally lower. We do not believe our use of a CBSA-based wage index would change our conclusion, however, as noted below, we will continue to monitor provider cost data.

Moreover, section 623(b) of the MMA and section 422(a)(2) of BIPA prohibit the granting of new exceptions for the composite rate, except for pediatric ESRD facilities.

b. Revised Labor-Related Portion

The current composite rate wage index is applied to two different labor-related shares, 40.65 percent for independent facilities and 36.78 percent for hospital-based facilities. Given the age of the cost data used to develop these shares, we proposed revising the labor-related portion of the composite rate based on the ESRD composite rate market basket contained in our May 2003 Report to Congress on developing a bundled outpatient ESRD payment system. We proposed the use of a single labor-related share of 53.711 percent that would apply to both hospital-based and independent facilities. This proportion was based on the sum of the labor-related categories of costs that comprise the ESRD market basket. (70 FR 45796 through 45798). We received the following comments on this proposal.

Comment: One commenter criticized our use of the ESRD composite rate market basket developed from CY 1997 data to revise the labor related-portion of composite rate costs subject to wage index adjustment. The commenter maintained that the use of more recent cost report data to develop a revised labor-related share would be more reflective of current economic realities. Another commenter recommended that we use the hospital market basket, which was developed from fiscal year 2002 data, instead. The commenter reasoned that the hospital market basket would be a more appropriate measure, not only because it reflects more recent data, but also because ESRD facilities compete with hospitals for labor and use the same vendors for supplies.

Response: Calendar year 1997 was the most recent year for which relatively complete data were available when the ESRD composite rate market basket was developed in 2003. Until the ESRD market basket is rebased to incorporate later data, we believe it is proper to use the 1997-based ESRD composite rate market basket to determine the labor-related share because it reflects the cost structures of ESRD facilities serving Medicare beneficiaries. We will continue to evaluate the available data on ESRD facilities and expect to periodically rebase the ESRD market basket when appropriate.

We disagree with the commenter's recommendation to use the 2002-based hospital market basket to determine the labor-related share for ESRD facilities. We believe the 1997-based ESRD market basket best reflects the types of medical services and cost structures used by ESRD facilities. This is consistent with other payment systems that use individually tailored market baskets to determine their labor-related share.

Comment: One commenter attempted to replicate the basic composite payment rate (that is, the payment rate

prior to application of the drug add on and patient specific case-mix adjustments) for the Orlando, Florida MSA. The commenter inquired whether the proposed revised wage index for each urban/rural area is applied to 40 percent or 100 percent of the wage adjustment reflected in the current composite payment rates.

Response: The published wage index applicable to each urban/rural area is neither applied to 40 percent nor 100 percent of the composite payment rate's current wage adjustment. We currently multiply the current wage index by one of two different labor-related portions of the composite payment rates, depending on the type of ESRD facility. The portion is 40.65 percent for independent facilities and 36.78 percent for hospital-based facilities. However, the composite rate wage index itself is a blend of two separate wage index values. Of the current measure, 40 percent, is based on the hospital wage index calculated from fiscal year 1986 data, and 60 percent is based on the hospital wage index calculated from 1980 BLS data.

However, in our August 8, 2005 proposed rule, we proposed making the labor-related portion the same for both hospital-based and independent ESRD facilities. That proportion (53.711 percent) was developed from the labor-related components of the ESRD composite rate market basket. Moreover, the proposed wage index is not a blended measure. It was developed exclusively from hospital wage and employment data for fiscal year 2002 obtained from the Medicare hospital cost reports. We proposed to apply the proposed wage index values to 100 percent of the 53.711 percent labor-related share. The revised labor-related shares applicable to hospital-based and independent ESRD facilities were contained in Table 26 of our proposed rule. Using data contained in Table 26 in our proposed rule, we calculated that the basic composite payment rate for hospital-based ESRD facilities in the Orlando MSA would have been $71.12 × 0.9677 + $61.29 or $130.11. For independent facilities the rate would have been $68.94 × 0.9677 + $59.41 or $126.12.

c. Adoption of Floor/Ceiling Wage Index Values and Transition Policies for Implementation of Revised Wage Index

The wage index values in the current composite payment rates reflect a floor of 0.90 and a cap of 1.30. In the August 8, 2005 rule, we proposed eliminating the cap because of the effect it has had on restricting payments in high wage areas. While we stated that we would like to remove the floor as well, we were concerned that its immediate elimination could adversely affect beneficiary access to dialysis. To mitigate any potential adverse impact, we proposed a gradual reduction in the floor to 0.85 for 2006 and 0.80 in 2007, with a reevaluation of continued need for the floor in 2008.

We also proposed a 2-year transition for implementation of the new composite payment rates, but only for those facilities whose CBSA based payment decreased. Under the proposed transition, facilities would be paid the higher of the new wage adjusted composite rate, or a 50–50 blend of the current wage adjusted rate and the new wage adjusted rate (70 FR 45798 through 45799). We received the following comments regarding the proposed ceiling and floor wage index values and the 2-year transition period.

Comment: Several commenters representing facilities whose payment rates would increase as a result of the revised urban/rural definitions and wage index values, endorsed the immediate introduction of the new basic composite payment rates. Other commenters either supported the proposed 2-year transition period, or recommended longer transitions of varying duration to mitigate further the impact of reduced composite payments.

Response: Most commenters endorsed our proposal to provide for a transition period to mitigate the impact of the revised CBSA based composite payment rates, but believed that a 2-year transition was too short. The recommended transition periods, generally ranged from 3 to 5 years, with several commenters supporting a transition period of 5 years. We agree that a longer transition period is appropriate to allow ESRD facilities sufficient time to adjust to the new CBSA based wage index, and have selected 4 years as a reasonable compromise among the recommended alternatives. While a 4-year transition is longer than the transition in other payment systems, we believe it is justified in the case of ESRD facilities because the wage data currently used for the wage index is over 20 years old. Thus, facilities need more than the usual transition. However, we will apply the 4-year transition period to all ESRD facilities, those whose base composite payment rates compared to those currently in effect increase as well as decrease. This represents a change from our proposed policy of applying a transition period only to those facilities whose composite payment rates decreased. We believe that a transition period of 4 years applied to all ESRD facilities achieves a reasonable balance between cushioning the impact for providers whose CBSA based composite payment rates decrease, and implementing the CBSA based wage index as quickly as possible.

Comment: We received several comments on our proposal to reduce gradually the wage index floor from its current level of 0.90, to 0.85 in 2006 and 0.80 in 2007. The comments included keeping the floor at 0.90, maintaining the floor at 0.90 but simultaneously increasing the ceiling from its current level of 1.30 to 1.40, and phasing out the floor as proposed, but also extending the phase out to the wage index ceiling as well.

Response: We recognize that only immediate elimination of the 0.90 floor could substantially reduce composite payments in locales where prevailing labor costs are lower. Although ESRD facilities in areas with wage levels below 0.90 have benefited from the application of the floor, we are concerned that its sudden elimination could adversely affect ESRD beneficiary access to care.

In the August 8, 2005 rule, we proposed lifting the wage index cap of 1.30 entirely in 2006 because it has restricted payments in areas with high labor costs. Under our proposal ESRD facilities whose base composite payment rate increased would receive the full payment amount per treatment without regard to the cap.

We have carefully reconsidered our proposal in light of concerns over the potential impact of the use of new CBSA-based geographic designations and wage index values on ESRD facilities that will experience a decrease in their composite payments. We believe that it would be more consistent and equitable for all ESRD facilities if we phased out the wage index floor and eliminated the ceiling. Accordingly, we are implementing a 4-year transition period that will apply to all ESRD facilities, those experiencing either an increase or decrease in their base composite payment rate for 2006. Although the present wage index ceiling of 1.30 will be eliminated in 2006, facilities whose payments have been restricted by the ceiling would not receive 100 percent of their otherwise applicable base composite payment per treatment without the ceiling until 2009. This occurs as a result of blending the proportion of old MSA and new CBSA based wage adjusted composite rates over the 4-year transition period as shown in Table 20. By applying blended shares during the 4-year transition period to all ESRD facilities, we believe we can achieve a balance between our goals of preserving access to care in low

wage areas and the ultimate elimination of constraints on the wage index. The wage index floors, caps, and blended shares of the base composite payment rates applicable to all ESRD facilities for CYs 2006 through 2009 are detailed in Table 20.

TABLE 20.—WAGE INDEX TRANSITION BLEND

CY payment	Floor	Ceiling	Old MSA	New CBSA
2006	0.85*	None	75	25
2007	0.80*	None	50	50
2008	Reassess	None	25	75
2009	Reassess	None	0	100

*Each wage index floor is multiplied by a budget neutrality adjustment factor. For CY 2006 the budget neutrality adjustment is 1.045287 resulting in an actual wage index floor of .8885.

We plan to reassess the continuing application of the wage index floor in connection with the 2008 update to the composite payment rates.

An example of how the base composite payment rates would be blended during the 4 year transition period to reflect the old MSA and new CBSA based geographic designating follows.

Assume an ESRD facility whose base composite payment rate (that is, without regard to any case-mix adjustments) is $135.00 per treatment in 2005. Based on the new CBSA wage index designations, its base composite payment rate is $145.00 for 2006. This facility's blended rate during each year of the 4 year transition period would be as follows:

CY 2006—.75 × $135.00 + .25 × $145.00 = $137.50

CY 2007—.50 × $135.00 + .50 × $145.00 = $140.00

CY 2008—.25 × $135.00 + .75 × $145.00 = $142.00

CY 2009—0 × $135.00 + 1.0 × $145.00 = $145.00

Of course, this hypothetical assumes that the calculated rate of $145.00 for 2006 will not change in 2007 and the following years. In actuality, it would because of annual revisions to the wage index. However, the example serves to illustrate how the new CBSA-based composite payment rates will be phased-in during the 4 year transition period, regardless of whether an ESRD facility's base composite payment increases or decreases in 2006 compared to 2005.

Comment: One commenter endorsed our proposed elimination of the wage index cap, but was concerned that isolated rural ESRD facilities, whose wage levels are generally lower than those prevailing in urban locales, could be adversely affected, even with the proposed floor wage index values. The commenter recommended that these facilities continue to be permitted to receive the isolated essential facility exception to their otherwise applicable composite payment rate under § 413.186.

Response: ESRD facilities which have been granted exceptions to their composite payment rates, including those granted under the authority of § 413.186, have the option of either retaining their exceptions, or becoming subject to the case-mix adjusted composite payments, at any time. Beyond this option, we have no discretion to grant new exceptions under § 413.186. Section 422(a)(2) of BIPA, as amended by section 623(b) of the MMA, eliminated the granting of new exceptions to the composite payment rates except for ESRD facilities qualifying as pediatric facilities. We believe that the wage index floors of 0.85 for 2006 and 0.80 for 2007, the extension of the transition period from 2 to 4 years, and affording facilities the option of retaining previously granted exceptions, should help cushion any potential adverse impact to ESRD facilities located in isolated rural areas.

Comment: Several commenters expressed particular concern over the relatively large reduction in payment rates for dialysis facilities in certain rural areas and in certain States. While most of these locales were unspecified, some commenters used Ohio out as an example, noting that implementation of the revised wage index would reduce payment rates in Ohio by more than $14.00 per treatment. The commenters requested that we provide a State specific impact analysis, delay implementation of the proposed revised composite payment rates for a 6-month period, and engage in dialysis community discussions to determine whether changes to the proposed wage index floor values and modification of the proposed 2-year transition period, would be necessary.

Response: We strive to engage in discussions with the dialysis community concerning ESRD payment policies, such as our open door forums where the dialysis community can provide input to CMS on ESRD issues. Moreover, as noted previously, based in part on the comments received we are implementing revisions to our proposed policies regarding continuation of the wage index floor and ceiling, and the duration of the transition period. These changes should lessen the impact of our adoption of CBSA-based geographic designations and revised wage index values for ESRD services. We believe that no 6-month delay in implementing the revised composite payment rates is necessary. To respond to the commenter's suggestion that we provide a State-specific impact analysis, we have provided this information in Table 52. We are extending the proposed 2-year transition to a 4-year transition to allow affected facilities to adjust to the revised wage indices.

Comment: We received several comments which endorsed a phase in of the new CBSA based wage index based on a 50/50 split, similar to the wage index adopted in connection with the FY 2006 SNF PPS.

Response: The FY 2006 SNF PPS, published in the **Federal Register** on August 4, 2005 (70 FR 45026), adopted a wage index consisting of a blend of 50 percent of the FY 2006 MSA-based wage index, and 50 percent of the FY 2006 CBSA-based wage index, both of which were developed from FY 2002 hospital wage data (70 FR 45041). This blended wage index is effective for a 1 year period. As the current ESRD wage index is obsolete, we see no reason to use it as a part of a blended measure which would then reflect an outdated wage index as part of a transition mechanism.

4. ESRD Wage Index Budget Neutrality

Section 623(d) of MMA added section 1881(b)(12)(E)(i) to the Act which requires that any revisions to the ESRD composite rate payment system as a result of the MMA provision (including the geographic adjustment) be made in a budget neutral manner. This means that aggregate payments to ESRD facilities in CY 2006 should be the same aggregate payments that would have

been made if we had not made any changes to the geographic adjusters. We proposed to apply a budget neutrality adjustment factor directly to the revised ESRD wage index values, rather than applying the adjustment to the base composite payment rates. We believe this is the simplest approach since it allows us to maintain a base composite rate for hospital-based facilities and one for independent facilities during the transition from the current wage adjustments to the revised wage adjustments. The proposed budget neutrality adjustment was 1.023024.

For CY 2006, we will apply the budget neutrality adjustment factor directly to the revised ESRD wage index values. Since we will be transitioning to the new wage index over a 4-year period, the computation of the adjustment factor varies slightly from our proposal. However, the basic method and concept is still the same as we proposed.

In order to compute the proposed wage index BNF, we used treatment counts from CY 2004 billing data and facility-specific CY 2005 composite payment rates. For purposes of adjusting the labor-related portion of the CY 2006 ESRD composite rate, we are using the most recent hospital wage data applicable to FY 2006 payments as discussed previously in this section.

Using treatment counts from the 2004 claims and facility-specific CY 2005 composite payment rates, we computed the estimated dollar amount each ESRD provider would have received had there been no changes to the ESRD wage index. This becomes the target amount of expenditures for all ESRD facilities. Then we computed the estimated dollar amount that would have been paid to the same ESRD facilities using the revised ESRD wage index (including the 4-year transition). In the first year of the transition, ESRD facilities receive 25 percent of the CBSA wage adjusted composite rate and 75 percent of the current composite rate. This becomes the first year new amount of expenditures for all ESRD facilities.

After comparing these two dollar amounts (target amount divided by first year new amount), we calculate an adjustment factor that, when multiplied by the ESRD wage index, will result in the target amount of expenditures for all ESRD facilities. Since the ESRD wage index is only applied to the labor-related portion of the composite rate payment, we computed the adjustment based on that proportion (53.711 percent). We apply the estimated budget neutrality adjustment factor to the revised wage index values for CY 2006 to ensure that estimated aggregate payments to ESRD facilities would remain budget neutral. The final wage index BNF adjustment factor is 1.045287.

Applying this budget neutrality to the wage index floor of 0.8500, results in a wage index floor for 2006 of 0.8885.

As stated earlier, the data used to compute the BNF are the wage index values in Table 21 and 22, the 2004 100 percent Outpatient Standard Analytic File (SAF) Claims, and geographic location information for each facility which may be found through Dialysis Facility Compare.

Comment: Several commenters requested that we provide the data and methodology used to compute the wage index BNF.

Response: The purpose of the wage index BNF is to achieve budget neutrality as required by section 623(d) of the MMA, which added section 1881(b)(12)(E)(i) to the Act. That provision of the Act requires that any revisions to the ESRD composite rate payment system (including the geographic adjustment) must be made in a budget neutral manner. This means that aggregate payments to ESRD facilities in CY 2006 should be the same as aggregate payments that would have been made if we had not made any changes to the geographic adjusters. The methodology for computing the wage index BNF is described earlier in this section.

The data used to compute the BNF are the wage index values in Tables 21 and 22, the 2004 100 percent Outpatient Standard Analytic File (SAF) Claims, and geographic location information for each provider which may be found through Dialysis Facility Compare. Dialysis Facility Compare can be found by going to the following link: *http://www.medicare/Download/DOWNLOADDB.asp.*

d. Wage Index Table

The following two tables show the ESRD wage indexes for urban areas (Table 21) and rural areas (Table 22).

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TABLE 21: Proposed ESRD Wage Index for URBAN Areas Based on CBSA Labor Market Areas

CBSA Code	Urban Area (Constituent Counties)	Wage Index
10180	Abilene, TX	0.8885
	Callahan County, TX	
	Jones County, TX	
	Taylor County, TX	
10380	Aguadilla-Isabela-San Sebastián, PR	0.8885
	Aguada Municipio, PR	
	Aguadilla Municipio, PR	
	Añasco Municipio, PR	
	Isabela Municipio, PR	
	Lares Municipio, PR	
	Moca Municipio, PR	
	Rincón Municipio, PR	
	San Sebastián Municipio, PR	
10420	Akron, OH	0.9389
	Portage County, OH	
	Summit County, OH	
10500	Albany, GA	0.9019
	Baker County, GA	
	Dougherty County, GA	
	Lee County, GA	
	Terrell County, GA	
	Worth County, GA	
10580	Albany-Schenectady-Troy, NY	0.8978
	Albany County, NY	
	Rensselaer County, NY	
	Saratoga County, NY	
	Schenectady County, NY	
	Schoharie County, NY	
10740	Albuquerque, NM	1.0123
	Bernalillo County, NM	
	Sandoval County, NM	
	Torrance County, NM	
	Valencia County, NM	
10780	Alexandria, LA	0.8885
	Grant Parish, LA	
	Rapides Parish, LA	
10900	Allentown-Bethlehem-Easton, PA-NJ	1.0263
	Warren County, NJ	
	Carbon County, PA	
	Lehigh County, PA	
	Northampton County, PA	
11020	Altoona, PA	0.9349
	Blair County, PA	
11100	Amarillo, TX	0.9571
	Armstrong County, TX	
	Carson County, TX	
	Potter County, TX	
	Randall County, TX	
11180	Ames, IA	0.9968
	Story County, IA	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
11260	Anchorage, AK	1.2434
	Anchorage Municipality, AK	
	Matanuska-Susitna Borough, AK	
11300	Anderson, IN	0.8975
	Madison County, IN	
11340	Anderson, SC	0.9404
	Anderson County, SC	
11460	Ann Arbor, MI	1.1351
	Washtenaw County, MI	
11500	Anniston-Oxford, AL	0.8885
	Calhoun County, AL	
11540	Appleton, WI	0.9709
	Calumet County, WI	
	Outagamie County, WI	
11700	Asheville, NC	0.9705
	Buncombe County, NC	
	Haywood County, NC	
	Henderson County, NC	
	Madison County, NC	
12020	Athens-Clarke County, GA	1.0301
	Clarke County, GA	
	Madison County, GA	
	Oconee County, GA	
	Oglethorpe County, GA	
12060	Atlanta-Sandy Springs-Marietta, GA	1.0236
	Barrow County, GA	
	Bartow County, GA	
	Butts County, GA	
	Carroll County, GA	
	Cherokee County, GA	
	Clayton County, GA	
	Cobb County, GA	
	Coweta County, GA	
	Dawson County, GA	
	DeKalb County, GA	
	Douglas County, GA	
	Fayette County, GA	
	Forsyth County, GA	
	Fulton County, GA	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Gwinnett County, GA	
	Haralson County, GA	
	Heard County, GA	
	Henry County, GA	
	Jasper County, GA	
	Lamar County, GA	
	Meriwether County, GA	
	Newton County, GA	
	Paulding County, GA	
	Pickens County, GA	
	Pike County, GA	
	Rockdale County, GA	
	Spalding County, GA	
	Walton County, GA	
12100	Atlantic City, NJ	1.2141
	Atlantic County, NJ	
12220	Auburn-Opelika, AL	0.8885
	Lee County, AL	
12260	Augusta-Richmond County, GA-SC	1.0189
	Burke County, GA	
	Columbia County, GA	
	McDuffie County, GA	
	Richmond County, GA	
	Aiken County, SC	
	Edgefield County, SC	
12420	Austin-Round Rock, TX	0.9864
	Bastrop County, TX	
	Caldwell County, TX	
	Hays County, TX	
	Travis County, TX	
	Williamson County, TX	
12540	Bakersfield, CA	1.0944
	Kern County, CA	
12580	Baltimore-Towson, MD	1.0345
	Anne Arundel County, MD	
	Baltimore County, MD	
	Carroll County, MD	
	Harford County, MD	
	Howard County, MD	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Queen Anne's County, MD	
	Baltimore City, MD	
12620	Bangor, ME	1.0446
	Penobscot County, ME	
12700	Barnstable Town, MA	1.3171
	Barnstable County, MA	
12940	Baton Rouge, LA	0.8982
	Ascension Parish, LA	
	East Baton Rouge Parish, LA	
	East Feliciana Parish, LA	
	Iberville Parish, LA	
	Livingston Parish, LA	
	Pointe Coupee Parish, LA	
	St. Helena Parish, LA	
	West Baton Rouge Parish, LA	
	West Feliciana Parish, LA	
12980	Battle Creek, MI	0.9939
	Calhoun County, MI	
13020	Bay City, MI	0.9766
	Bay County, MI	
13140	Beaumont-Port Arthur, TX	0.8885
	Hardin County, TX	
	Jefferson County, TX	
	Orange County, TX	
13380	Bellingham, WA	1.2262
	Whatcom County, WA	
13460	Bend, OR	1.1274
	Deschutes County, OR	
13644	Bethesda-Frederick-Gaithersburg, MD	1.2003
	Frederick County, MD	
	Montgomery County, MD	
13740	Billings, MT	0.9234
	Carbon County, MT	
	Yellowstone County, MT	
13780	Binghamton, NY	0.8950
	Broome County, NY	
	Tioga County, NY	
13820	Birmingham-Hoover, AL	0.9365
	Bibb County, AL	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Blount County, AL	
	Chilton County, AL	
	Jefferson County, AL	
	St. Clair County, AL	
	Shelby County, AL	
	Walker County, AL	
13900	Bismarck, ND	0.8885
	Burleigh County, ND	
	Morton County, ND	
13980	Blacksburg-Christiansburg-Radford, VA	0.8885
	Giles County, VA	
	Montgomery County, VA	
	Pulaski County, VA	
	Radford City, VA	
14020	Bloomington, IN	0.8885
	Greene County, IN	
	Monroe County, IN	
	Owen County, IN	
14060	Bloomington-Normal, IL	0.9486
	McLean County, IL	
14260	Boise City-Nampa, ID	0.9462
	Ada County, ID	
	Boise County, ID	
	Canyon County, ID	
	Gem County, ID	
	Owyhee County, ID	
14484	Boston-Quincy, MA	1.2081
	Norfolk County, MA	
	Plymouth County, MA	
	Suffolk County, MA	
14500	Boulder, CO	1.0175
	Boulder County, CO	
14540	Bowling Green, KY	0.8885
	Edmonson County, KY	
	Warren County, KY	
14740	Bremerton-Silverdale, WA	1.1158
	Kitsap County, WA	
14860	Bridgeport-Stamford-Norwalk, CT	1.3162
	Fairfield County, CT	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
15180	Brownsville-Harlingen, TX	1.0248
	Cameron County, TX	
15260	Brunswick, GA	0.9733
	Brantley County, GA	
	Glynn County, GA	
	McIntosh County, GA	
15380	Buffalo-Niagara Falls, NY	0.9942
	Erie County, NY	
	Niagara County, NY	
15500	Burlington, NC	0.9308
	Alamance County, NC	
15540	Burlington-South Burlington, VT	0.9836
	Chittenden County, VT	
	Franklin County, VT	
	Grand Isle County, VT	
15764	Cambridge-Newton-Framingham, MA	1.1678
	Middlesex County, MA	
15804	Camden, NJ	1.0993
	Burlington County, NJ	
	Camden County, NJ	
	Gloucester County, NJ	
15940	Canton-Massillon, OH	0.9340
	Carroll County, OH	
	Stark County, OH	
15980	Cape Coral-Fort Myers, FL	0.9780
	Lee County, FL	
16180	Carson City, NV	1.0697
	Carson City, NV	
16220	Casper, WY	0.9435
	Natrona County, WY	
16300	Cedar Rapids, IA	0.9225
	Benton County, IA	
	Jones County, IA	
	Linn County, IA	
16580	Champaign-Urbana, IL	1.0028
	Champaign County, IL	
	Ford County, IL	
	Piatt County, IL	
16620	Charleston, WV	0.8885

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Boone County, WV	
	Clay County, WV	
	Kanawha County, WV	
	Lincoln County, WV	
	Putnam County, WV	
16700	Charleston-North Charleston, SC	0.9664
	Berkeley County, SC	
	Charleston County, SC	
	Dorchester County, SC	
16740	Charlotte-Gastonia-Concord, NC-SC	1.0192
	Anson County, NC	
	Cabarrus County, NC	
	Gaston County, NC	
	Mecklenburg County, NC	
	Union County, NC	
	York County, SC	
16820	Charlottesville, VA	1.0648
	Albemarle County, VA	
	Fluvanna County, VA	
	Greene County, VA	
	Nelson County, VA	
	Charlottesville City, VA	
16860	Chattanooga, TN-GA	0.9500
	Catoosa County, GA	
	Dade County, GA	
	Walker County, GA	
	Hamilton County, TN	
	Marion County, TN	
	Sequatchie County, TN	
16940	Cheyenne, WY	0.9172
	Laramie County, WY	
16974	Chicago-Naperville-Joliet, IL	1.1279
	Cook County, IL	
	DeKalb County, IL	
	DuPage County, IL	
	Grundy County, IL	
	Kane County, IL	
	Kendall County, IL	
	McHenry County, IL	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Will County, IL	
17020	Chico, CA	1.0987
	Butte County, CA	
17140	Cincinnati-Middletown, OH-KY-IN	1.0050
	Dearborn County, IN	
	Franklin County, IN	
	Ohio County, IN	
	Boone County, KY	
	Bracken County, KY	
	Campbell County, KY	
	Gallatin County, KY	
	Grant County, KY	
	Kenton County, KY	
	Pendleton County, KY	
	Brown County, OH	
	Butler County, OH	
	Clermont County, OH	
	Hamilton County, OH	
	Warren County, OH	
17300	Clarksville, TN-KY	0.8885
	Christian County, KY	
	Trigg County, KY	
	Montgomery County, TN	
	Stewart County, TN	
17420	Cleveland, TN	0.8885
	Bradley County, TN	
	Polk County, TN	
17460	Cleveland-Elyria-Mentor, OH	0.9630
	Cuyahoga County, OH	
	Geauga County, OH	
	Lake County, OH	
	Lorain County, OH	
	Medina County, OH	
17660	Coeur d'Alene, ID	1.0084
	Kootenai County, ID	
17780	College Station-Bryan, TX	0.9303
	Brazos County, TX	
	Burleson County, TX	
	Robertson County, TX	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
17820	Colorado Springs, CO	0.9897
	El Paso County, CO	
	Teller County, CO	
17860	Columbia, MO	0.8885
	Boone County, MO	
	Howard County, MO	
17900	Columbia, SC	0.9467
	Calhoun County, SC	
	Fairfield County, SC	
	Kershaw County, SC	
	Lexington County, SC	
	Richland County, SC	
	Saluda County, SC	
17980	Columbus, GA-AL	0.8948
	Russell County, AL	
	Chattahoochee County, GA	
	Harris County, GA	
	Marion County, GA	
	Muscogee County, GA	
18020	Columbus, IN	1.0022
	Bartholomew County, IN	
18140	Columbus, OH	1.0307
	Delaware County, OH	
	Fairfield County, OH	
	Franklin County, OH	
	Licking County, OH	
	Madison County, OH	
	Morrow County, OH	
	Pickaway County, OH	
	Union County, OH	
18580	Corpus Christi, TX	0.8937
	Aransas County, TX	
	Nueces County, TX	
	San Patricio County, TX	
18700	Corvallis, OR	1.1215
	Benton County, OR	
19060	Cumberland, MD-WV	0.9739
	Allegany County, MD	
	Mineral County, WV	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
19124	Dallas-Plano-Irving, TX	1.0691
	Collin County, TX	
	Dallas County, TX	
	Delta County, TX	
	Denton County, TX	
	Ellis County, TX	
	Hunt County, TX	
	Kaufman County, TX	
	Rockwall County, TX	
19140	Dalton, GA	0.9490
	Murray County, GA	
	Whitfield County, GA	
19180	Danville, IL	0.9437
	Vermilion County, IL	
19260	Danville, VA	0.8885
	Pittsylvania County, VA	
	Danville City, VA	
19340	Davenport-Moline-Rock Island, IA-IL	0.9119
	Henry County, IL	
	Mercer County, IL	
	Rock Island County, IL	
	Scott County, IA	
19380	Dayton, OH	0.9474
	Greene County, OH	
	Miami County, OH	
	Montgomery County, OH	
	Preble County, OH	
19460	Decatur, AL	0.8885
	Lawrence County, AL	
	Morgan County, AL	
19500	Decatur, IL	0.8885
	Macon County, IL	
19660	Deltona-Daytona Beach-Ormond Beach, FL	0.9720
	Volusia County, FL	
19740	Denver-Aurora, CO	1.1209
	Adams County, CO	
	Arapahoe County, CO	
	Broomfield County, CO	
	Clear Creek County, CO	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Denver County, CO	
	Douglas County, CO	
	Elbert County, CO	
	Gilpin County, CO	
	Jefferson County, CO	
	Park County, CO	
19780	Des Moines, IA	1.0107
	Dallas County, IA	
	Guthrie County, IA	
	Madison County, IA	
	Polk County, IA	
	Warren County, IA	
19804	Detroit-Livonia-Dearborn, MI	1.0896
	Wayne County, MI	
20020	Dothan, AL	0.8885
	Geneva County, AL	
	Henry County, AL	
	Houston County, AL	
20100	Dover, DE	1.0219
	Kent County, DE	
20220	Dubuque, IA	0.9433
	Dubuque County, IA	
20260	Duluth, MN-WI	1.0676
	Carlton County, MN	
	St. Louis County, MN	
	Douglas County, WI	
20500	Durham, NC	1.0708
	Chatham County, NC	
	Durham County, NC	
	Orange County, NC	
	Person County, NC	
20740	Eau Claire, WI	0.9618
	Chippewa County, WI	
	Eau Claire County, WI	
20764	Edison, NJ	1.1758
	Middlesex County, NJ	
	Monmouth County, NJ	
	Ocean County, NJ	
	Somerset County, NJ	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
20940	El Centro, CA	0.9309
	Imperial County, CA	
21060	Elizabethtown, KY	0.9201
	Hardin County, KY	
	Larue County, KY	
21140	Elkhart-Goshen, IN	1.0063
	Elkhart County, IN	
21300	Elmira, NY	0.8885
	Chemung County, NY	
21340	El Paso, TX	0.9384
	El Paso County, TX	
21500	Erie, PA	0.9133
	Erie County, PA	
21604	Essex County, MA	1.1015
	Essex County, MA	
21660	Eugene-Springfield, OR	1.1308
	Lane County, OR	
21780	Evansville, IN-KY	0.9108
	Gibson County, IN	
	Posey County, IN	
	Vanderburgh County, IN	
	Warrick County, IN	
	Henderson County, KY	
	Webster County, KY	
21820	Fairbanks, AK	1.1925
	Fairbanks North Star Borough, AK	
21940	Fajardo, PR	0.8885
	Ceiba Municipio, PR	
	Fajardo Municipio, PR	
	Luquillo Municipio, PR	
22020	Fargo, ND-MN	0.8885
	Cass County, ND	
	Clay County, MN	
22140	Farmington, NM	0.8894
	San Juan County, NM	
22180	Fayetteville, NC	0.9842
	Cumberland County, NC	
	Hoke County, NC	
22220	Fayetteville-Springdale-Rogers, AR-MO	0.9053

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Benton County, AR	
	Madison County, AR	
	Washington County, AR	
	McDonald County, MO	
22380	Flagstaff, AZ	1.2640
	Coconino County, AZ	
22420	Flint, MI	1.1138
	Genesee County, MI	
22500	Florence, SC	0.9352
	Darlington County, SC	
	Florence County, SC	
22520	Florence-Muscle Shoals, AL	0.8885
	Colbert County, AL	
	Lauderdale County, AL	
22540	Fond du Lac, WI	1.0077
	Fond du Lac County, WI	
22660	Fort Collins-Loveland, CO	1.0580
	Larimer County, CO	
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	1.0904
	Broward County, FL	
22900	Fort Smith, AR-OK	0.8885
	Crawford County, AR	
	Franklin County, AR	
	Sebastian County, AR	
	Le Flore County, OK	
	Sequoyah County, OK	
23020	Fort Walton Beach-Crestview-Destin, FL	0.9274
	Okaloosa County, FL	
23060	Fort Wayne, IN	1.0236
	Allen County, IN	
	Wells County, IN	
	Whitley County, IN	
23104	Fort Worth-Arlington, TX	0.9916
	Johnson County, TX	
	Parker County, TX	
	Tarrant County, TX	
	Wise County, TX	
23420	Fresno, CA	1.1015
	Fresno County, CA	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
23460	Gadsden, AL	0.8885
	Etowah County, AL	
23540	Gainesville, FL	0.9813
	Alachua County, FL	
	Gilchrist County, FL	
23580	Gainesville, GA	0.9276
	Hall County, GA	
23844	Gary, IN	0.9820
	Jasper County, IN	
	Lake County, IN	
	Newton County, IN	
	Porter County, IN	
24020	Glens Falls, NY	0.8947
	Warren County, NY	
	Washington County, NY	
24140	Goldsboro, NC	0.9172
	Wayne County, NC	
24220	Grand Forks, ND-MN	0.8885
	Polk County, MN	
	Grand Forks County, ND	
24300	Grand Junction, CO	0.9982
	Mesa County, CO	
24340	Grand Rapids-Wyoming, MI	0.9815
	Barry County, MI	
	Ionia County, MI	
	Kent County, MI	
	Newaygo County, MI	
24500	Great Falls, MT	0.9462
	Cascade County, MT	
24540	Greeley, CO	1.0003
	Weld County, CO	
24580	Green Bay, WI	0.9912
	Brown County, WI	
	Kewaunee County, WI	
	Oconto County, WI	
24660	Greensboro-High Point, NC	0.9516
	Guilford County, NC	
	Randolph County, NC	
	Rockingham County, NC	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
24780	Greenville, NC	0.9852
	Greene County, NC	
	Pitt County, NC	
24860	Greenville, SC	1.0481
	Greenville County, SC	
	Laurens County, SC	
	Pickens County, SC	
25020	Guayama, PR	0.8885
	Arroyo Municipio, PR	
	Guayama Municipio, PR	
	Patillas Municipio, PR	
25060	Gulfport-Biloxi, MS	0.9333
	Hancock County, MS	
	Harrison County, MS	
	Stone County, MS	
25180	Hagerstown-Martinsburg, MD-WV	0.9919
	Washington County, MD	
	Berkeley County, WV	
	Morgan County, WV	
25260	Hanford-Corcoran, CA	1.0491
	Kings County, CA	
25420	Harrisburg-Carlisle, PA	0.9735
	Cumberland County, PA	
	Dauphin County, PA	
	Perry County, PA	
25500	Harrisonburg, VA	0.9500
	Rockingham County, VA	
	Harrisonburg City, VA	
25540	Hartford-West Hartford-East Hartford, CT	1.1574
	Hartford County, CT	
	Litchfield County, CT	
	Middlesex County, CT	
	Tolland County, CT	
25620	Hattiesburg, MS	0.8885
	Forrest County, MS	
	Lamar County, MS	
	Perry County, MS	
25860	Hickory-Lenoir-Morganton, NC	0.9325
	Alexander County, NC	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Burke County, NC	
	Caldwell County, NC	
	Catawba County, NC	
25980	Hinesville-Fort Stewart, GA	0.9594
	Liberty County, GA	
	Long County, GA	
26100	Holland-Grand Haven, MI	0.9465
	Ottawa County, MI	
26180	Honolulu, HI	1.1722
	Honolulu County, HI	
26300	Hot Springs, AR	0.9413
	Garland County, AR	
26380	Houma-Bayou Cane-Thibodaux, LA	0.8885
	Lafourche Parish, LA	
	Terrebonne Parish, LA	
26420	Houston-Baytown-Sugar Land, TX	1.0449
	Austin County, TX	
	Brazoria County, TX	
	Chambers County, TX	
	Fort Bend County, TX	
	Galveston County, TX	
	Harris County, TX	
	Liberty County, TX	
	Montgomery County, TX	
	San Jacinto County, TX	
	Waller County, TX	
26580	Huntington-Ashland, WV-KY-OH	0.9906
	Boyd County, KY	
	Greenup County, KY	
	Lawrence County, OH	
	Cabell County, WV	
	Wayne County, WV	
26620	Huntsville, AL	0.9560
	Limestone County, AL	
	Madison County, AL	
26820	Idaho Falls, ID	0.9847
	Bonneville County, ID	
	Jefferson County, ID	
26900	Indianapolis, IN	1.0369

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Boone County, IN	
	Brown County, IN	
	Hamilton County, IN	
	Hancock County, IN	
	Hendricks County, IN	
	Johnson County, IN	
	Marion County, IN	
	Morgan County, IN	
	Putnam County, IN	
	Shelby County, IN	
26980	Iowa City, IA	1.0188
	Johnson County, IA	
	Washington County, IA	
27060	Ithaca, NY	1.0236
	Tompkins County, NY	
27100	Jackson, MI	0.9725
	Jackson County, MI	
27140	Jackson, MS	0.8885
	Copiah County, MS	
	Hinds County, MS	
	Madison County, MS	
	Rankin County, MS	
	Simpson County, MS	
27180	Jackson, TN	0.9370
	Chester County, TN	
	Madison County, TN	
27260	Jacksonville, FL	0.9711
	Baker County, FL	
	Clay County, FL	
	Duval County, FL	
	Nassau County, FL	
	St. Johns County, FL	
27340	Jacksonville, NC	0.8885
	Onslow County, NC	
27500	Janesville, WI	0.9970
	Rock County, WI	
27620	Jefferson City, MO	0.8885
	Callaway County, MO	
	Cole County, MO	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Moniteau County, MO	
	Osage County, MO	
27740	Johnson City, TN	0.8885
	Carter County, TN	
	Unicoi County, TN	
	Washington County, TN	
27780	Johnstown, PA	0.8885
	Cambria County, PA	
27860	Jonesboro, AR	0.8885
	Craighead County, AR	
	Poinsett County, AR	
27900	Joplin, MO	0.8971
	Jasper County, MO	
	Newton County, MO	
28020	Kalamazoo-Portage, MI	1.0851
	Kalamazoo County, MI	
	Van Buren County, MI	
28100	Kankakee-Bradley, IL	1.1207
	Kankakee County, IL	
28140	Kansas City, MO-KS	0.9905
	Franklin County, KS	
	Johnson County, KS	
	Leavenworth County, KS	
	Linn County, KS	
	Miami County, KS	
	Wyandotte County, KS	
	Bates County, MO	
	Caldwell County, MO	
	Cass County, MO	
	Clay County, MO	
	Clinton County, MO	
	Jackson County, MO	
	Lafayette County, MO	
	Platte County, MO	
	Ray County, MO	
28420	Kennewick-Richland-Pasco, WA	1.1100
	Benton County, WA	
	Franklin County, WA	
28660	Killeen-Temple-Fort Hood, TX	0.8912

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Bell County, TX	
	Coryell County, TX	
	Lampasas County, TX	
28700	Kingsport-Bristol-Bristol, TN-VA	0.8885
	Hawkins County, TN	
	Sullivan County, TN	
	Bristol City, VA	
	Scott County, VA	
	Washington County, VA	
28740	Kingston, NY	0.9674
	Ulster County, NY	
28940	Knoxville, TN	0.8885
	Anderson County, TN	
	Blount County, TN	
	Knox County, TN	
	Loudon County, TN	
	Union County, TN	
29020	Kokomo, IN	0.9939
	Howard County, IN	
	Tipton County, IN	
29100	La Crosse, WI-MN	0.9997
	Houston County, MN	
	La Crosse County, WI	
29140	Lafayette, IN	0.9132
	Benton County, IN	
	Carroll County, IN	
	Tippecanoe County, IN	
29180	Lafayette, LA	0.8885
	Lafayette Parish, LA	
	St. Martin Parish, LA	
29340	Lake Charles, LA	0.8885
	Calcasieu Parish, LA	
	Cameron Parish, LA	
29404	Lake County-Kenosha County, IL-WI	1.0901
	Lake County, IL	
	Kenosha County, WI	
29460	Lakeland, FL	0.9316
	Polk County, FL	
29540	Lancaster, PA	1.0133

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Lancaster County, PA	
29620	Lansing-East Lansing, MI	1.0238
	Clinton County, MI	
	Eaton County, MI	
	Ingham County, MI	
29700	Laredo, TX	0.8885
	Webb County, TX	
29740	Las Cruces, NM	0.8885
	Dona Ana County, NM	
29820	Las Vegas-Paradise, NV	1.1955
	Clark County, NV	
29940	Lawrence, KS	0.8924
	Douglas County, KS	
30020	Lawton, OK	0.8885
	Comanche County, OK	
30140	Lebanon, PA	0.8885
	Lebanon County, PA	
30300	Lewiston, ID-WA	1.0334
	Nez Perce County, ID	
	Asotin County, WA	
30340	Lewiston-Auburn, ME	0.9754
	Androscoggin County, ME	
30460	Lexington-Fayette, KY	0.9486
	Bourbon County, KY	
	Clark County, KY	
	Fayette County, KY	
	Jessamine County, KY	
	Scott County, KY	
	Woodford County, KY	
30620	Lima, OH	0.9643
	Allen County, OH	
30700	Lincoln, NE	1.0677
	Lancaster County, NE	
	Seward County, NE	
30780	Little Rock-North Little Rock, AR	0.9143
	Faulkner County, AR	
	Grant County, AR	
	Lonoke County, AR	
	Perry County, AR	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Pulaski County, AR	
	Saline County, AR	
30860	Logan, UT-ID	0.9579
	Franklin County, ID	
	Cache County, UT	
30980	Longview, TX	0.9125
	Gregg County, TX	
	Rusk County, TX	
	Upshur County, TX	
31020	Longview, WA	1.0013
	Cowlitz County, WA	
31084	Los Angeles-Long Beach-Glendale, CA	1.2317
	Los Angeles County, CA	
31140	Louisville, KY-IN	0.9670
	Clark County, IN	
	Floyd County, IN	
	Harrison County, IN	
	Washington County, IN	
	Bullitt County, KY	
	Henry County, KY	
	Jefferson County, KY	
	Meade County, KY	
	Nelson County, KY	
	Oldham County, KY	
	Shelby County, KY	
	Spencer County, KY	
	Trimble County, KY	
31180	Lubbock, TX	0.9181
	Crosby County, TX	
	Lubbock County, TX	
31340	Lynchburg, VA	0.9085
	Amherst County, VA	
	Appomattox County, VA	
	Bedford County, VA	
	Campbell County, VA	
	Bedford City, VA	
	Lynchburg City, VA	
31420	Macon, GA	0.9871
	Bibb County, GA	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Crawford County, GA	
	Jones County, GA	
	Monroe County, GA	
	Twiggs County, GA	
31460	Madera, CA	0.9108
	Madera County, CA	
31540	Madison, WI	1.1142
	Columbia County, WI	
	Dane County, WI	
	Iowa County, WI	
31700	Manchester-Nashua, NH	1.0823
	Hillsborough County, NH	
	Merrimack County, NH	
31900	Mansfield, OH	1.0339
	Richland County, OH	
32420	Mayagüez, PR	0.8885
	Hormigueros Municipio, PR	
	Mayagüez Municipio, PR	
32580	McAllen-Edinburg-Pharr, TX	0.9339
	Hidalgo County, TX	
32780	Medford, OR	1.0688
	Jackson County, OR	
32820	Memphis, TN-MS-AR	0.9823
	Crittenden County, AR	
	DeSoto County, MS	
	Marshall County, MS	
	Tate County, MS	
	Tunica County, MS	
	Fayette County, TN	
	Shelby County, TN	
	Tipton County, TN	
32900	Merced, CA	1.1612
	Merced County, CA	
33124	Miami-Miami Beach-Kendall, FL	1.0192
	Miami-Dade County, FL	
33140	Michigan City-La Porte, IN	0.9825
	LaPorte County, IN	
33260	Midland, TX	0.9945
	Midland County, TX	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
33340	Milwaukee-Waukesha-West Allis, WI	1.0605
	Milwaukee County, WI	
	Ozaukee County, WI	
	Washington County, WI	
	Waukesha County, WI	
33460	Minneapolis-St. Paul-Bloomington, MN-WI	1.1577
	Anoka County, MN	
	Carver County, MN	
	Chisago County, MN	
	Dakota County, MN	
	Hennepin County, MN	
	Isanti County, MN	
	Ramsey County, MN	
	Scott County, MN	
	Sherburne County, MN	
	Washington County, MN	
	Wright County, MN	
	Pierce County, WI	
	St. Croix County, WI	
33540	Missoula, MT	0.9902
	Missoula County, MT	
33660	Mobile, AL	0.8885
	Mobile County, AL	
33700	Modesto, CA	1.2423
	Stanislaus County, CA	
33740	Monroe, LA	0.8885
	Ouachita Parish, LA	
	Union Parish, LA	
33780	Monroe, MI	0.9897
	Monroe County, MI	
33860	Montgomery, AL	0.9008
	Autauga County, AL	
	Elmore County, AL	
	Lowndes County, AL	
	Montgomery County, AL	
34060	Morgantown, WV	0.8885
	Monongalia County, WV	
	Preston County, WV	
34100	Morristown, TN	0.8885

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Grainger County, TN	
	Hamblen County, TN	
	Jefferson County, TN	
34580	Mount Vernon-Anacortes, WA	1.0927
	Skagit County, WA	
34620	Muncie, IN	0.9334
	Delaware County, IN	
34740	Muskegon-Norton Shores, MI	1.0102
	Muskegon County, MI	
34820	Myrtle Beach-Conway-North Myrtle Beach, SC	0.9339
	Horry County, SC	
34900	Napa, CA	1.3216
	Napa County, CA	
34940	Naples-Marco Island, FL	1.0598
	Collier County, FL	
34980	Nashville-Davidson--Murfreesboro, TN	1.0233
	Cannon County, TN	
	Cheatham County, TN	
	Davidson County, TN	
	Dickson County, TN	
	Hickman County, TN	
	Macon County, TN	
	Robertson County, TN	
	Rutherford County, TN	
	Smith County, TN	
	Sumner County, TN	
	Trousdale County, TN	
	Williamson County, TN	
	Wilson County, TN	
35004	Nassau-Suffolk, NY	1.3295
	Nassau County, NY	
	Suffolk County, NY	
35084	Newark-Union, NJ-PA	1.2421
	Essex County, NJ	
	Hunterdon County, NJ	
	Morris County, NJ	
	Sussex County, NJ	
	Union County, NJ	
	Pike County, PA	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
35300	New Haven-Milford, CT	1.2425
	New Haven County, CT	
35380	New Orleans-Metairie-Kenner, LA	0.9402
	Jefferson Parish, LA	
	Orleans Parish, LA	
	Plaquemines Parish, LA	
	St. Bernard Parish, LA	
	St. Charles Parish, LA	
	St. John the Baptist Parish, LA	
	St. Tammany Parish, LA	
35644	New York-Wayne-White Plains, NY-NJ	1.3785
	Bergen County, NJ	
	Hudson County, NJ	
	Passaic County, NJ	
	Bronx County, NY	
	Kings County, NY	
	New York County, NY	
	Putnam County, NY	
	Queens County, NY	
	Richmond County, NY	
	Rockland County, NY	
	Westchester County, NY	
35660	Niles-Benton Harbor, MI	0.9281
	Berrien County, MI	
35980	Norwich-New London, CT	1.1859
	New London County, CT	
36084	Oakland-Fremont-Hayward, CA	1.6041
	Alameda County, CA	
	Contra Costa County, CA	
36100	Ocala, FL	0.9329
	Marion County, FL	
36140	Ocean City, NJ	1.1510
	Cape May County, NJ	
36220	Odessa, TX	1.0332
	Ector County, TX	
36260	Ogden-Clearfield, UT	0.9438
	Davis County, UT	
	Morgan County, UT	
	Weber County, UT	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
36420	Oklahoma City, OK	0.9440
	Canadian County, OK	
	Cleveland County, OK	
	Grady County, OK	
	Lincoln County, OK	
	Logan County, OK	
	McClain County, OK	
	Oklahoma County, OK	
36500	Olympia, WA	1.1422
	Thurston County, WA	
36540	Omaha-Council Bluffs, NE-IA	0.9993
	Harrison County, IA	
	Mills County, IA	
	Pottawattamie County, IA	
	Cass County, NE	
	Douglas County, NE	
	Sarpy County, NE	
	Saunders County, NE	
	Washington County, NE	
36740	Orlando, FL	0.9893
	Lake County, FL	
	Orange County, FL	
	Osceola County, FL	
	Seminole County, FL	
36780	Oshkosh-Neenah, WI	0.9599
	Winnebago County, WI	
36980	Owensboro, KY	0.9178
	Daviess County, KY	
	Hancock County, KY	
	McLean County, KY	
37100	Oxnard-Thousand Oaks-Ventura, CA	1.2148
	Ventura County, CA	
37340	Palm Bay-Melbourne-Titusville, FL	1.0285
	Brevard County, FL	
37460	Panama City-Lynn Haven, FL	0.8885
	Bay County, FL	
37620	Parkersburg-Marietta, WV-OH	0.8885
	Washington County, OH	
	Pleasants County, WV	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Wirt County, WV	
	Wood County, WV	
37700	Pascagoula, MS	0.8885
	George County, MS	
	Jackson County, MS	
37860	Pensacola-Ferry Pass-Brent, FL	0.8885
	Escambia County, FL	
	Santa Rosa County, FL	
37900	Peoria, IL	0.9272
	Marshall County, IL	
	Peoria County, IL	
	Stark County, IL	
	Tazewell County, IL	
	Woodford County, IL	
37964	Philadelphia, PA	1.1538
	Bucks County, PA	
	Chester County, PA	
	Delaware County, PA	
	Montgomery County, PA	
	Philadelphia County, PA	
38060	Phoenix-Mesa-Scottsdale, AZ	1.0586
	Maricopa County, AZ	
	Pinal County, AZ	
38220	Pine Bluff, AR	0.9073
	Cleveland County, AR	
	Jefferson County, AR	
	Lincoln County, AR	
38300	Pittsburgh, PA	0.9246
	Allegheny County, PA	
	Armstrong County, PA	
	Beaver County, PA	
	Butler County, PA	
	Fayette County, PA	
	Washington County, PA	
	Westmoreland County, PA	
38340	Pittsfield, MA	1.0642
	Berkshire County, MA	
38540	Pocatello, ID	0.9774
	Bannock County, ID	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Power County, ID	
38660	Ponce, PR	0.8885
	Juana Díaz Municipio, PR	
	Ponce Municipio, PR	
	Villalba Municipio, PR	
38860	Portland-South Portland-Biddeford, ME	1.0852
	Cumberland County, ME	
	Sagadahoc County, ME	
	York County, ME	
38900	Portland-Vancouver-Beaverton, OR-WA	1.1776
	Clackamas County, OR	
	Columbia County, OR	
	Multnomah County, OR	
	Washington County, OR	
	Yamhill County, OR	
	Clark County, WA	
	Skamania County, WA	
38940	Port St. Lucie-Fort Pierce, FL	1.0581
	Martin County, FL	
	St. Lucie County, FL	
39100	Poughkeepsie-Newburgh-Middletown, NY	1.1384
	Dutchess County, NY	
	Orange County, NY	
39140	Prescott, AZ	1.0316
	Yavapai County, AZ	
39300	Providence-New Bedford-Fall River, RI-MA	1.1463
	Bristol County, MA	
	Bristol County, RI	
	Kent County, RI	
	Newport County, RI	
	Providence County, RI	
	Washington County, RI	
39340	Provo-Orem, UT	0.9930
	Juab County, UT	
	Utah County, UT	
39380	Pueblo, CO	0.9014
	Pueblo County, CO	
39460	Punta Gorda, FL	0.9674
	Charlotte County, FL	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
39540	Racine, WI	0.9404
	Racine County, WI	
39580	Raleigh-Cary, NC	1.0130
	Franklin County, NC	
	Johnston County, NC	
	Wake County, NC	
39660	Rapid City, SD	0.9394
	Meade County, SD	
	Pennington County, SD	
39740	Reading, PA	1.0125
	Berks County, PA	
39820	Redding, CA	1.2756
	Shasta County, CA	
39900	Reno-Sparks, NV	1.1479
	Storey County, NV	
	Washoe County, NV	
40060	Richmond, VA	0.9750
	Amelia County, VA	
	Caroline County, VA	
	Charles City County, VA	
	Chesterfield County, VA	
	Cumberland County, VA	
	Dinwiddie County, VA	
	Goochland County, VA	
	Hanover County, VA	
	Henrico County, VA	
	King and Queen County, VA	
	King William County, VA	
	Louisa County, VA	
	New Kent County, VA	
	Powhatan County, VA	
	Prince George County, VA	
	Sussex County, VA	
	Colonial Heights City, VA	
	Hopewell City, VA	
	Petersburg City, VA	
	Richmond City, VA	
40140	Riverside-San Bernardino-Ontario, CA	1.1526
	Riverside County, CA	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	San Bernardino County, CA	
40220	Roanoke, VA	0.8885
	Botetourt County, VA	
	Craig County, VA	
	Franklin County, VA	
	Roanoke County, VA	
	Roanoke City, VA	
	Salem City, VA	
40340	Rochester, MN	1.1635
	Dodge County, MN	
	Olmsted County, MN	
	Wabasha County, MN	
40380	Rochester, NY	0.9534
	Livingston County, NY	
	Monroe County, NY	
	Ontario County, NY	
	Orleans County, NY	
	Wayne County, NY	
40420	Rockford, IL	1.0436
	Boone County, IL	
	Winnebago County, IL	
40484	Rockingham County-Strafford County, NH	1.0844
	Rockingham County, NH	
	Strafford County, NH	
40580	Rocky Mount, NC	0.9319
	Edgecombe County, NC	
	Nash County, NC	
40660	Rome, GA	0.9840
	Floyd County, GA	
40900	Sacramento--Arden-Arcade--Roseville, CA	1.3556
	El Dorado County, CA	
	Placer County, CA	
	Sacramento County, CA	
	Yolo County, CA	
40980	Saginaw-Saginaw Township North, MI	0.9500
	Saginaw County, MI	
41060	St. Cloud, MN	1.0416
	Benton County, MN	
	Stearns County, MN	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
41100	St. George, UT	0.9817
	Washington County, UT	
41140	St. Joseph, MO-KS	0.9950
	Doniphan County, KS	
	Andrew County, MO	
	Buchanan County, MO	
	DeKalb County, MO	
41180	St. Louis, MO-IL	0.9359
	Bond County, IL	
	Calhoun County, IL	
	Clinton County, IL	
	Jersey County, IL	
	Macoupin County, IL	
	Madison County, IL	
	Monroe County, IL	
	St. Clair County, IL	
	Crawford County, MO	
	Franklin County, MO	
	Jefferson County, MO	
	Lincoln County, MO	
	St. Charles County, MO	
	St. Louis County, MO	
	Warren County, MO	
	Washington County, MO	
	St. Louis City, MO	
41420	Salem, OR	1.0915
	Marion County, OR	
	Polk County, OR	
41500	Salinas, CA	1.4768
	Monterey County, CA	
41540	Salisbury, MD	0.9474
	Somerset County, MD	
	Wicomico County, MD	
41620	Salt Lake City, UT	0.9848
	Salt Lake County, UT	
	Summit County, UT	
	Tooele County, UT	
41660	San Angelo, TX	0.8885
	Irion County, TX	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Tom Green County, TX	
41700	San Antonio, TX	0.9387
	Atascosa County, TX	
	Bandera County, TX	
	Bexar County, TX	
	Comal County, TX	
	Guadalupe County, TX	
	Kendall County, TX	
	Medina County, TX	
	Wilson County, TX	
41740	San Diego-Carlsbad-San Marcos, CA	1.1930
	San Diego County, CA	
41780	Sandusky, OH	0.9427
	Erie County, OH	
41884	San Francisco-San Mateo-Redwood City, CA	1.5673
	Marin County, CA	
	San Francisco County, CA	
	San Mateo County, CA	
41900	San Germán-Cabo Rojo, PR	0.8885
	Cabo Rojo Municipio, PR	
	Lajas Municipio, PR	
	Sabana Grande Municipio, PR	
	San Germán Municipio, PR	
41940	San Jose-Sunnyvale-Santa Clara, CA	1.5783
	San Benito County, CA	
	Santa Clara County, CA	
41980	San Juan-Caguas-Guaynabo, PR	0.8885
	Aguas Buenas Municipio, PR	
	Aibonito Municipio, PR	
	Arecibo Municipio, PR	
	Barceloneta Municipio, PR	
	Barranquitas Municipio, PR	
	Bayamón Municipio, PR	
	Caguas Municipio, PR	
	Camuy Municipio, PR	
	Canóvanas Municipio, PR	
	Carolina Municipio, PR	
	Cataño Municipio, PR	
	Cayey Municipio, PR	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Ciales Municipio, PR	
	Cidra Municipio, PR	
	Comerío Municipio, PR	
	Corozal Municipio, PR	
	Dorado Municipio, PR	
	Florida Municipio, PR	
	Guaynabo Municipio, PR	
	Gurabo Municipio, PR	
	Hatillo Municipio, PR	
	Humacao Municipio, PR	
	Juncos Municipio, PR	
	Las Piedras Municipio, PR	
	Loíza Municipio, PR	
	Manatí Municipio, PR	
	Maunabo Municipio, PR	
	Morovis Municipio, PR	
	Naguabo Municipio, PR	
	Naranjito Municipio, PR	
	Orocovis Municipio, PR	
	Quebradillas Municipio, PR	
	Río Grande Municipio, PR	
	San Juan Municipio, PR	
	San Lorenzo Municipio, PR	
	Toa Alta Municipio, PR	
	Toa Baja Municipio, PR	
	Trujillo Alto Municipio, PR	
	Vega Alta Municipio, PR	
	Vega Baja Municipio, PR	
	Yabucoa Municipio, PR	
42020	San Luis Obispo-Paso Robles, CA	1.1863
	San Luis Obispo County, CA	
42044	Santa Ana-Anaheim-Irvine, CA	1.2082
	Orange County, CA	
42060	Santa Barbara-Santa Maria-Goleta, CA	1.2224
	Santa Barbara County, CA	
42100	Santa Cruz-Watsonville, CA	1.5853
	Santa Cruz County, CA	
42140	Santa Fe, NM	1.1415
	Santa Fe County, NM	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
42220	Santa Rosa-Petaluma, CA	1.4104
	Sonoma County, CA	
42260	Sarasota-Bradenton-Venice, FL	1.0076
	Manatee County, FL	
	Sarasota County, FL	
42340	Savannah, GA	0.9889
	Bryan County, GA	
	Chatham County, GA	
	Effingham County, GA	
42540	Scranton--Wilkes-Barre, PA	0.8927
	Lackawanna County, PA	
	Luzerne County, PA	
	Wyoming County, PA	
42644	Seattle-Bellevue-Everett, WA	1.2101
	King County, WA	
	Snohomish County, WA	
43100	Sheboygan, WI	0.9315
	Sheboygan County, WI	
43300	Sherman-Denison, TX	0.9938
	Grayson County, TX	
43340	Shreveport-Bossier City, LA	0.9157
	Bossier Parish, LA	
	Caddo Parish, LA	
	De Soto Parish, LA	
43580	Sioux City, IA-NE-SD	0.9806
	Woodbury County, IA	
	Dakota County, NE	
	Dixon County, NE	
	Union County, SD	
43620	Sioux Falls, SD	1.0071
	Lincoln County, SD	
	McCook County, SD	
	Minnehaha County, SD	
	Turner County, SD	
43780	South Bend-Mishawaka, IN-MI	1.0231
	St. Joseph County, IN	
	Cass County, MI	
43900	Spartanburg, SC	0.9587
	Spartanburg County, SC	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
44060	Spokane, WA	1.1399
	Spokane County, WA	
44100	Springfield, IL	0.9190
	Menard County, IL	
	Sangamon County, IL	
44140	Springfield, MA	1.0712
	Franklin County, MA	
	Hampden County, MA	
	Hampshire County, MA	
44180	Springfield, MO	0.8885
	Christian County, MO	
	Dallas County, MO	
	Greene County, MO	
	Polk County, MO	
	Webster County, MO	
44220	Springfield, OH	0.8885
	Clark County, OH	
44300	State College, PA	0.8885
	Centre County, PA	
44700	Stockton, CA	1.1819
	San Joaquin County, CA	
44940	Sumter, SC	0.8885
	Sumter County, SC	
45060	Syracuse, NY	1.0008
	Madison County, NY	
	Onondaga County, NY	
	Oswego County, NY	
45104	Tacoma, WA	1.1228
	Pierce County, WA	
45220	Tallahassee, FL	0.9081
	Gadsden County, FL	
	Jefferson County, FL	
	Leon County, FL	
	Wakulla County, FL	
45300	Tampa-St. Petersburg-Clearwater, FL	0.9651
	Hernando County, FL	
	Hillsborough County, FL	
	Pasco County, FL	
	Pinellas County, FL	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
45460	Terre Haute, IN	0.8885
	Clay County, IN	
	Sullivan County, IN	
	Vermillion County, IN	
	Vigo County, IN	
45500	Texarkana, TX-Texarkana, AR	0.8885
	Miller County, AR	
	Bowie County, TX	
45780	Toledo, OH	1.0008
	Fulton County, OH	
	Lucas County, OH	
	Ottawa County, OH	
	Wood County, OH	
45820	Topeka, KS	0.9324
	Jackson County, KS	
	Jefferson County, KS	
	Osage County, KS	
	Shawnee County, KS	
	Wabaunsee County, KS	
45940	Trenton-Ewing, NJ	1.1325
	Mercer County, NJ	
46060	Tucson, AZ	0.9415
	Pima County, AZ	
46140	Tulsa, OK	0.8930
	Creek County, OK	
	Okmulgee County, OK	
	Osage County, OK	
	Pawnee County, OK	
	Rogers County, OK	
	Tulsa County, OK	
	Wagoner County, OK	
46220	Tuscaloosa, AL	0.9037
	Greene County, AL	
	Hale County, AL	
	Tuscaloosa County, AL	
46340	Tyler, TX	0.9583
	Smith County, TX	
46540	Utica-Rome, NY	0.8885
	Herkimer County, NY	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Oneida County, NY	
46660	Valdosta, GA	0.9268
	Brooks County, GA	
	Echols County, GA	
	Lanier County, GA	
	Lowndes County, GA	
46700	Vallejo-Fairfield, CA	1.5612
	Solano County, CA	
46940	Vero Beach, FL	0.9861
	Indian River County, FL	
47020	Victoria, TX	0.8885
	Calhoun County, TX	
	Goliad County, TX	
	Victoria County, TX	
47220	Vineland-Millville-Bridgeton, NJ	1.0272
	Cumberland County, NJ	
47260	Virginia Beach-Norfolk-Newport News, VA-NC	0.9197
	Currituck County, NC	
	Gloucester County, VA	
	Isle of Wight County, VA	
	James City County, VA	
	Mathews County, VA	
	Surry County, VA	
	York County, VA	
	Chesapeake City, VA	
	Hampton City, VA	
	Newport News City, VA	
	Norfolk City, VA	
	Poquoson City, VA	
	Portsmouth City, VA	
	Suffolk City, VA	
	Virginia Beach City, VA	
	Williamsburg City, VA	
47300	Visalia-Porterville, CA	1.0581
	Tulare County, CA	
47380	Waco, TX	0.8904
	McLennan County, TX	
47580	Warner Robins, GA	0.9037
	Houston County, GA	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
47644	Warren-Farmington Hills-Troy, MI	1.0318
	Lapeer County, MI	
	Livingston County, MI	
	Macomb County, MI	
	Oakland County, MI	
	St. Clair County, MI	
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	1.1421
	District of Columbia, DC	
	Calvert County, MD	
	Charles County, MD	
	Prince George's County, MD	
	Arlington County, VA	
	Clarke County, VA	
	Fairfax County, VA	
	Fauquier County, VA	
	Loudoun County, VA	
	Prince William County, VA	
	Spotsylvania County, VA	
	Stafford County, VA	
	Warren County, VA	
	Alexandria City, VA	
	Fairfax City, VA	
	Falls Church City, VA	
	Fredericksburg City, VA	
	Manassas City, VA	
	Manassas Park City, VA	
	Jefferson County, WV	
47940	Waterloo-Cedar Falls, IA	0.8945
	Black Hawk County, IA	
	Bremer County, IA	
	Grundy County, IA	
48140	Wausau, WI	1.0024
	Marathon County, WI	
48260	Weirton-Steubenville, WV-OH	0.8885
	Jefferson County, OH	
	Brooke County, WV	
	Hancock County, WV	
48300	Wenatchee, WA	1.0526
	Chelan County, WA	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Douglas County, WA	
48424	West Palm Beach-Boca Raton-Boynton Beach, FL	1.0523
	Palm Beach County, FL	
48540	Wheeling, WV-OH	0.8885
	Belmont County, OH	
	Marshall County, WV	
	Ohio County, WV	
48620	Wichita, KS	0.9568
	Butler County, KS	
	Harvey County, KS	
	Sedgwick County, KS	
	Sumner County, KS	
48660	Wichita Falls, TX	0.8885
	Archer County, TX	
	Clay County, TX	
	Wichita County, TX	
48700	Williamsport, PA	0.8885
	Lycoming County, PA	
48864	Wilmington, DE-MD-NJ	1.0945
	New Castle County, DE	
	Cecil County, MD	
	Salem County, NJ	
48900	Wilmington, NC	1.0016
	Brunswick County, NC	
	New Hanover County, NC	
	Pender County, NC	
49020	Winchester, VA-WV	1.0677
	Frederick County, VA	
	Winchester City, VA	
	Hampshire County, WV	
49180	Winston-Salem, NC	0.9349
	Davie County, NC	
	Forsyth County, NC	
	Stokes County, NC	
	Yadkin County, NC	
49340	Worcester, MA	1.1527
	Worcester County, MA	
49420	Yakima, WA	1.0615
	Yakima County, WA	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
49500	Yauco, PR	0.8885
	Guánica Municipio, PR	
	Guayanilla Municipio, PR	
	Peñuelas Municipio, PR	
	Yauco Municipio, PR	
49620	York-Hanover, PA	0.9770
	York County, PA	
49660	Youngstown-Warren-Boardman, OH-PA	0.8993
	Mahoning County, OH	
	Trumbull County, OH	
	Mercer County, PA	
49700	Yuba City, CA	1.1416
	Sutter County, CA	
	Yuba County, CA	
49740	Yuma, AZ	0.9539
	Yuma County, AZ	

TABLE 22: Proposed ESRD Wage Index for RURAL Areas Based on CBSA Labor Market Areas

CBSA Code	Nonurban Area	Wage Index
01	Alabama	0.8885
02	Alaska	1.2519
03	Arizona	0.9165
04	Arkansas	0.8885
05	California	1.1555
06	Colorado	0.9805
07	Connecticut	1.2261
08	Delaware	1.0013
10	Florida	0.8956
11	Georgia	0.8885
12	Hawaii	1.1029
13	Idaho	0.8885
14	Illinois	0.8885
15	Indiana	0.9015
16	Iowa	0.8894
17	Kansas	0.8885
18	Kentucky	0.8885
19	Louisiana	0.8885
20	Maine	0.9243
21	Maryland	0.9777
22	Massachusetts	1.2560
23	Michigan	0.9298
24	Minnesota	0.9546
25	Mississippi	0.8885
26	Missouri	0.8885
27	Montana	0.9159
28	Nebraska	0.9049
29	Nevada	0.9476
30	New Hampshire	1.1307
32	New Mexico	0.9026
33	New York	0.8885
34	North Carolina	0.8927
35	North Dakota	0.8885
36	Ohio	0.9226
37	Oklahoma	0.8885
38	Oregon	1.0271
39	Pennsylvania	0.8885
42	South Carolina	0.9029
43	South Dakota	0.8948
44	Tennessee	0.8885
45	Texas	0.8885
46	Utah	0.8885
47	Vermont	1.0275
48	Virgin Islands	0.8885
49	Virginia	0.8885
50	Washington	1.0986
51	West Virginia	0.8885
52	Wisconsin	0.9940
53	Wyoming	0.9676

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4. Miscellaneous Comments on ESRD Issues

We propose to make no changes to the existing case-mix adjustment system. We proposed to maintain the existing system as established in the CY 2005 final rule (69 FR 66238) and implemented on April 1, 2005.

Comment: One commenter recommended that we stop the implementation of the basic case-mix adjustment. The commenter was critical of the case-mix adjustment because this commenter could not calculate the impact on their payment of one of the case-mix variables, specifically, weight. This commenter did not want to report weight as a case-mix variable because of the fluctuations in this variable, that is, weight changes.

Response: Section 623(d)(1) of the MMA added section 1881(b)(12)(A) of the Act requiring that the outpatient dialysis services included in the composite rate be case-mix adjusted. Case-mix variables are characteristics of the patients served that enable payment systems to reflect the resources needed by patients. The statute required adjustments to the composite payment rate for a limited number of patient characteristics. We implemented the case-mix adjustments required by the statute in April 2005, using research on case-mix variables to support our selection of a limited number of case-mix adjusters. A report on that research, entitled, ''Methodology for Developing a Basic Case-mix Adjustment for the Medicare ESRD Prospective Payment System'' is available on *www.sph.umich.edu/kecc*. The selected case-mix adjusters are age, low body mass index (BMI), and body surface area (BSA). BSA and low BMI were selected because they are a better predictor of cost of care than using weight alone. Height and weight are the case-mix variables that we use to calculate BMI and BSA adjusters. For this reason, and because we think that facilities should be easily able to report a case-mix variable that should be part of each patient's ongoing care plan, we will continue to require reporting of the patient's weight for purposes of calculating the case-mix adjusters.

Comment: There were several comments recommending that we explore the option of adding variables to the existing basic case-mix adjustments. Commenters recommended including variables that measured improved survival rates, creating a new code for ESRD patients with diabetes, and adding measures that reflect improvements in the quality of life for ESRD patients. Comments indicated that the current case-mix adjustments do not adequately compensate providers for resources used or the intensity of care that is required to provide services to the frail elderly, and patients with ambulatory limitations or selected comorbid conditions. In addition, commenters recommended that we should consider a variable that adjusts for time in treatment; specifically recommending that we consider the potential predictive power of a variable that exported the interval following the initial 6 months of ESRD treatments because the intensity of care and resources could increase.

Response: We indicated in the proposed rule that we anticipated maintaining the basic case-mix adjustment as established in the CY 2005 final rule (69 FR 66238) and implemented on April 1, 2005. Although we understand the comments that we explore additional case-mix variables, we do not currently have the data that would be necessary to analyze the current case-mix adjustment variables and refine the basic system. Therefore, we believe that it is premature at this time to add additional variables to the basic case-mix adjustment system. Several of the variables recommended, including intensity of care, survival rates and quality of life improvement, are excellent recommendations as variables for exploration.

As we stated in the CY 2005 final rule, the basic case-mix system is adjusts for a limited number of patient characteristics, consistent with the provisions of section 1881(b)(12)(A) of the Act as added by section 623 of the MMA. The MMA legislation anticipated that work would continue toward the development of a more fully bundled case-mix payment system for ESRD. We are continuing to work towards a more fully bundled case-mix system through ongoing research and development of a demonstration project required by the MMA.

We have a contract with the University of Michigan to continue the research that was initiated in 2001 to explore a number of variables that could be predictive of resource use in a fully bundled case-mix adjusted system. This research will include exploring the predictive potential of variables available from existing data sources, including assessing the potential impact of comorbid conditions to predict payments. Several of the suggestions, specifically, survival rates, assessing improvements in the quality of life for ESRD patients, developing frailty/ambulatory limitation measures, require the construction of classification measures of functioning for disability and health. These are beyond the scope of our existing research efforts; however, over time, HHS may include efforts to develop classifications of functioning for disability and health measures, as well as add quality measurements as part of our payment systems.

In addition, we will be assessing the data submitted under the existing basic case-mix system. As the analysis of this data progresses, we will consider potential refinements to the basic case-mix system.

We are also working on a demonstration project that will assess the use of a fully case-mix adjusted payment system. Both the demonstration and the ongoing research will examine the impact of comorbid conditions on case-mix and payment.

Regarding the comment that we should create a reimbursement code for ESRD patients with diabetes, we note that we did analyze comorbid conditions as part of the research for the basic case-mix system. At that time diabetes was not found to be a significant predictor. In addition, our staff found that the reporting of comorbid conditions, including diabetes, was frequently limited. Therefore, as part of our training effort, we have encouraged facilities to report all comorbid conditions, and plan to use the reported data in our ongoing research related to refining the basic case-mix system. Thus, we will continue to assess the impact of diabetes as a case-mix variable and a predictor of resource use, but we will not be requesting, at this time, the creation of a new code for diabetic ESRD patients for payment.

Comment: One commenter expressed concern regarding the reporting of height and weight for individuals who are double amputees. The comments indicated because of the case-mix adjustments for these individuals, the average reimbursement was reduced by an average of $20 per treatment even though these patients generally require the same or additional treatment because they could be in a wheel chair or possibly transported by stretcher.

Response: We concur that there may be issues surrounding the reporting of the height and weight variables associated with double amputees. We have explored a number of reporting options for these patients in an attempt to resolve both clinical and operational issues related to the reporting of these values. We agree that requiring that the height for double amputees be measured ''as they present'' may not accurately measure the necessary dialysis dose, we also believe that the reported weight for

these patients would require adjusting if we instructed facilities to report height ''pre-amputation.''

Based on the available literature related to height and weight measurements for double amputees, we believe there is sufficient data from which to appropriately adjust weight if height is reported pre-amputation. We relied on the methodology in the K-DOQI ''Guidelines for Peritoneal Dialysis Adequacy.'' Appendix E, Guideline 9 contains instructions related to adjustments to weight for amputees. Based on those guidelines, we are adopting the following formula for adjusting weight using the adjustment factor for below the knee (BKA) double amputees which is the most common type of double amputation:

Pre-Amputation Weight = Actual Weight × 1.15

Therefore, for dialysis treatments provided on or after January 1, 2006, we will revise our claims processing instructions related to the reporting of height and weight for double amputee dialysis patients. Height would be reported ''pre-amputation'' and weight would be adjusted by 1.15 to reflect the ''pre-amputation'' weight.

Comment: We received a number of comments from ESRD patients expressing concern regarding the impact that any reductions in payment could have on their care. One ESRD patient expressed concern that if there were payment cuts, the facilities could be adversely impacted resulting in facilities closing.

Response: The intent of the changes in payments to ESRD facilities was to appropriately pay facilities based on the characteristics of the patients they treat, as well as the wage levels for the areas in which they are located. We note that all of the changes in payments as a result of the MMA legislation were done in a budget neutral manner. That is, aggregate payments to ESRD facilities remain constant. While the result of the changes we have made to the wage adjustment will result in redistributing payments to individual facilities, these changes more accurately pay facilities based on local wage levels. We understand the concerns expressed by these patients and have provided for a transition from the old, outdated wage adjustment to the revised adjustment to help mitigate any adverse impact to individual facilities. In addition, we have provided a 1.4 percent increase to the payment facilities receive for 2006 based on the projected increase in drug expenditure between 2005 and 2006.

5. Revisions to the Composite Payment Rate Exceptions Process

In response to the changes made by section 422 of BIPA and section 623 of MMA, in the August 8, 2005 proposed rule (70 FR 45840 through 45842), we proposed changes to the existing regulations at § 413.180 through § 413.192 (42 CFR Part 413, Subpart H) regarding criteria and application procedures for requesting an exception to the ESRD composite rate payment. We also proposed to revise § 413.170(b) to specify that subpart H provides procedures and criteria under which only a pediatric ESRD facility as specified in the statute may receive an exception.

a. Pediatric ESRD Facility Exception

Existing exception rates are protected under section 422(a)(2)(C) of BIPA. The ''protection'' clause for existing exception rates provides that exception rates in effect on December 1, 2000 (or approved based on an application by July 1, 2001) remain in effect as long as the facility's exception rate is higher than the updated composite rate. Pediatric ESRD facility exception rates granted under the provisions of section 623 of the MMA (hereinafter referred to as ''pediatric facility exception rates'') are not subject to the ''protection'' clause for existing exception rates. However, we proposed to change our regulations to continue pediatric facility exception rates in the same way as existing nonpediatric exception rates. Specifically, we proposed that both nonpediatric and pediatric facility exception rates would remain in effect until the facility notifies its fiscal intermediary that it wishes to give up its rate because its case-mix adjusted composite rate is higher. As section 422(a)(2)(B) of BIPA allows existing nonpediatric exception rates to continue in effect as long as the exception rate exceeds the facility's updated composite payment rate, we expected that each facility would compare its existing exception rates to its basic case-mix adjusted composite rates to determine which is the higher rate. We believe the determination as to whether an ESRD facility's exception rate per treatment will exceed its average case-mix adjusted composite rate per treatment is best left to the affected entity.

In the past, an ESRD facility could request an exception to its prospective composite payment rate within 180 days of the effective date of its new composite rate (s) or the date on which we opened a specific exception window. We proposed to revise § 413.180(d) to remove the requirement that an application for an exception must be filed within the 180-day window because we believe that the small volume of applications will make it feasible for us to accept applications on a rolling basis. Therefore, we proposed to revise § 413.180(d) to state that a pediatric ESRD facility may request an exception to its composite payment rate at any time after it has been in operation for at least 12 consecutive months. For a full discussion of our proposal, see the August 8, 2005 proposed rule (70 FR 45840 through 45842). We received the following comments on these issues:

Comment: Several commenters asked for clarification that CMS will continue to recognize the exceptions status of non pediatric ESRD facilities. The commenters stated that the proposed rule presents conflicting statements about the continuing validity of these exceptions.

Response: We agree, and we are revising proposed § 413.180(i) to include the statement that ''ESRD facilities electing to retain their nonpediatric or pediatric exception rates (including self-dialysis training) do not need to notify their intermediaries.'' An ESRD facility may notify its fiscal intermediary at any time if it wishes to give up its nonpediatric or pediatric exception rate. Thirty days after written notice is received by the intermediary, the facility will become subject to the new basic case-mix adjusted composite payment rate methodology. A facility's decision to give up its exception rate can not be subsequently rescinded or reversed.

Comment: One commenter is concerned that the composite rate as modified by the MMA will be maintained for patients under age 18 in many facilities that do not qualify for a pediatric exception because the pediatric population is below 50 percent of all patients dialyzed. Patients under age 18 require additional resources. The commenter recommends that a facility should qualify for a pediatric exception if 25 percent of its patients are under 21 years of age.

Response: Section 623 of the MMA amended BIPA to allow a pediatric ESRD facility that did not have an approved exception rate as of October 1, 2002, to file for an exception to its updated prospective payment rate. To apply for the exception rate, the MMA requires that the pediatric facility has to demonstrate that at least 50 percent of its patients are individuals under 18 years of age.

We believe the statute is very specific regarding the criteria a pediatric ESRD facility must satisfy in order to apply for

an exception rate. We have incorporated these statutory provisions in our proposed regulatory changes to § 413.170, § 413.182, and § 413.184. However, we note, that regardless of whether the pediatric exception is available to a facility, pediatric ESRD patients (defined as those under the age of 18) receive a specific case-mix adjustment factor when the composite payment rate is determined. None of the other case-mix adjustors that apply to nonpediatric patients (that is, the five age groups, low BMI, and BSA) is applicable to pediatric ESRD patients.

Comment: We received two comments supporting the proposed change to allow pediatric ESRD facilities to file an exception at anytime after it is in operation for at least 12 consecutive months.

Response: Previously, a pediatric ESRD facility that has been denied its exception would have to wait until a subsequent exception request. We have revised § 413.180(d) to provide that a pediatric ESRD facility that has been denied an exception may immediately file another exception request. However, a subsequent exception request must address the deficiencies cited in our determination letter.

b. Pediatric Facility Exception Request Process

Section 422 of BIPA prohibited CMS from providing exceptions to ESRD facilities on or after December 31, 2000. Section 623 of the MMA amended BIPA by restoring the exception process, but only for pediatric facilities that that did not have an approved exception rate as of October 1, 2002. To file for an exception, the pediatric facility would have to demonstrate that at least 50 percent of its patients are individuals under 18 years of age. Since the MMA restored the exception process only for pediatric facilities, we proposed to remove existing exception criteria that are not applicable to the newly defined pediatric facilities, including exceptions for isolated essential facilities, extraordinary circumstances, and frequency of dialysis as specified in regulations at § 413.182(b), (c), and (e). However, we proposed to retain the exception criterion for self-dialysis training costs under § 413.182(d) because some pediatric facilities may qualify for an exception on that basis. For a full discussion of our proposal, see the August 8, 2005 proposed rule (70 FR 45841). The comments received on these issues and our response to those comments are as follows:

Comment: Several commenters asked that we retain the exceptions process for all five previous exception criteria in order to preserve access to care for dialysis patients and to foster evolution in the patterns of dialysis care. Commenters pointed out that the recent experience with Hurricane Katrina underscores the need for an exception process to provide for continuity of dialysis care during extraordinary circumstances. Commenters included a recommendation that self-dialysis and more frequent dialysis should be preserved as exception options, noting that patients with congestive heart failure may require four dialysis treatments per week, and this is a growing segment of the ESRD population. Finally, the commenters stated that the exception for isolated essential facilities should be retained because of the potential impact on access to care resulting from the proposed changes in the composite payment rate wage index and reimbursement for ESRD drugs.

Response: We have determined that pediatric facilities would not qualify for an exception under most of the existing exception criteria because of the uniqueness of their patient population (at least 50 percent under age 18). In the past, ESRD facilities with high percentages of pediatric patients only qualified for exceptions under the ''atypical patient mix'' criterion specified at § 413.182(a) and § 413.184. We have, therefore, proposed to replace the ''atypical patient mix'' criteria with a more specific ''pediatric patient mix'' criteria and to retain this exception at proposed §§ 413.182 and 413.184. We proposed to eliminate the exception criteria that we believe do not apply to facilities with large numbers of pediatric patients (that is, exceptions on the basis of isolated essential facilities, extraordinary circumstances, and frequency of dialysis). Based on our experience in granting ESRD exceptions, we do not believe that a situation exists where any newly defined pediatric facility with the required volume of pediatric patients would qualify for an exception under the isolated essential facilities criterion. Further, we note that previous exception requests for ''frequency of dialysis'' were granted to ESRD facilities that dialyzed their patients less frequently than 3 times a week and not more frequently as suggested by the commenter. However, we proposed to retain the exception criterion for self-dialysis training costs under § 413.182(d) because we have found that some pediatric facilities may qualify for an exception on that basis.

With respect to Hurricane Katrina, we have taken into consideration that, in this type of emergency (an extraordinary circumstance), alternatives exist to ensure that ESRD patients will have continuing access to services in other ESRD facilities. Any ESRD facility that has adequate treatment capacity, and is located close to a displaced patient's home, would be glad to offer its dialysis services. However, if there are no remaining ESRD facilities nearby to voluntarily accept displaced patients, dialysis service will be made available to these patients that have been temporarily relocated to a local shelter or to another town. Displaced patients relocated to another town that are healthy enough to drive or to be driven to a dialysis facility, will receive dialysis services there. Displaced patients in temporary shelters will receive dialysis from providers or suppliers that will send the necessary equipment, personnel, and supplies to the shelter.

We are finalizing the changes to § 413.180 through § 413.192 as proposed. However, we have added language to § 413.180 regarding the intermediary notification discussed above. In addition, we are adding a technical clarification to proposed § 413.170 to cross-reference § 413.184 which specifies pediatric patient-mix requirements that pediatric ESRD facilities must meet to qualify for an exception.

H. Payment for Covered Outpatient Drugs and Biologicals

Medicare Part B covers a limited number of prescription drugs and biologicals. For the purposes of this rule, the term ''drugs'' will hereafter refer to both drugs and biologicals. Medicare Part B covered drugs not paid on a cost or prospective payment basis generally fall into three categories:

- Drugs furnished incident to a physician's service.
- DME drugs.
- Drugs specifically covered by statute (immunosuppressive drugs, for example).

Beginning in CY 2005, the vast majority of Medicare Part B drugs not paid on a cost or prospective payment basis are paid under the ASP methodology. The ASP methodology is based on data submitted to us quarterly by manufacturers. In addition to the payment for the drug, Medicare currently pays a dispensing fee for inhalation drugs, a furnishing fee for blood clotting factors, and a supplying fee for certain Part B drugs.

In this section of the preamble we discuss the August 8, 2005 (70 FR 45843) proposed changes and issues related to the determination of the payment amounts for covered Part B drugs and the separate payments

allowable for dispensing inhalation drugs, furnishing blood clotting factor, and supplying certain other Part B drugs. We also discussed proposed changes in how manufacturers calculate the ASP and in the ASP data reported to us.

1. ASP Issues

Section 303(c) of the MMA amended Title XVIII of the Act by adding new section 1847A. This new section establishes the use of the ASP methodology for payment for most drugs and biologicals not paid on a cost or prospective payment basis furnished on or after January 1, 2005. The ASP reporting requirements are set forth in section 1927(b) of the Act. Manufacturers must submit ASP data to us quarterly. The manufacturers' submissions are due to us not later than 30 days after the last day of each calendar quarter. The methodology for developing Medicare drug payment allowances based on the manufacturers' submitted ASP data is specified in the regulations in part 414, subpart K. Based on the data we receive, we update the Part B drug payment amounts quarterly.

In this section of the preamble, we discuss: Our proposed changes related to the methodology manufacturers use to calculate the ASP and apply the estimate of lagged price concessions in the ASP calculation; the reporting of ASP data; the weighting methodology we follow to establish the Medicare payment amounts using the ASP data; the comments received and our responses; and our final policy with respect to these issues.

a. Estimation Methodology for Lagged Price Concessions

Section 1847A(c)(5)(A) of the Act states that the ASP is to be calculated by the manufacturer on a quarterly basis. As a part of that calculation, manufacturers are to take into account price concessions such as—

- Volume discounts.
- Prompt pay discounts.
- Cash discounts.
- Free goods that are contingent on any purchase requirement.
- Chargebacks.
- Rebates (other than rebates under the Medicaid drug rebate program).

If the data on these price concessions are lagged, then the manufacturer is required to estimate costs attributable to these price concessions. Specifically, the manufacturer sums the price concessions for the most recent 12-month period available associated with all sales subject to the ASP reporting requirements. The manufacturer then calculates a percentage using this summed amount as the numerator and the corresponding total sales data as the denominator. This results in a 12-month rolling average price concession percentage that is applied to the total in dollars for the sales subject to the ASP reporting requirement for the quarter being submitted to determine the price concession estimate for the quarter. The methodology is specified in § 414.804(a)(3).

We identified a refinement of the ASP calculation and lagged price concession estimation methodology related to chargebacks that we believe improves the accuracy of the estimate. As a result, we proposed to clarify the ASP calculation in the August 8, 2005 proposed rule (70 FR 5843).

b. Price Concessions: Wholesaler Chargebacks

Wholesaler chargebacks are a type of price concession, generally paid on a lagged basis, that apply to sales to customers (for example, physicians) via a wholesaler (or distributor). Wholesaler chargeback arrangements may vary in scope and complexity. Under the current estimation methodology for lagged price concessions, total lagged price concessions, including lagged wholesaler chargebacks, for the 12-month period are divided by total sales for that same period to determine a ratio that is applied to the total sales for the reporting period. The ratio of lagged price concessions to sales is calculated over all sales, both indirect sales (sales to wholesalers and distributors and other similar entities that sells to others in the distribution chain) and direct sales (sales directly from manufacturer to providers, such as hospitals or HMOs). To the extent that the relationship between total dollars for indirect sales and total dollars for all sales is different for the reporting quarter and the 12-month period used, the current ratio methodology for estimating lagged price concessions may overstate or understate wholesaler chargebacks expected for the reporting period. A more accurate estimation of lagged price concessions would minimize the effect of quarter to quarter variations in the relationship between indirect sales and all sales. As a result, we proposed to revise § 414.804 to require manufacturers to calculate the ASP for direct sales independently from the ASP for all other sales subject to the ASP reporting requirement (indirect sales). Then, the manufacturer would calculate a weighted average of the direct sales ASP and the indirect sales ASP to submit to us.

We believed that the weighted average of direct sales ASP and indirect sales ASP would improve the overall accuracy of the ASP calculation, particularly for NDCs with significant fluctuations in the percentage of sales that are direct sales.

We proposed conforming changes to § 414.804 for the methodology for calculating the lagged price concessions percentage. We also proposed to revise the regulation to clarify that the estimation ratio methodology relates to lagged price concessions and also define ''direct sales'' and ''indirect sales'' in § 414.802. In addition, we requested comments about the advisability and potential effects of requiring manufacturers to calculate the ASP for direct sales, including price concessions, independently from the ASP for indirect sales and then calculating a weighted average of these ASPs to submit to us, as well as the proposed definitions of direct sales and indirect sales.

Comment: We received many comments on our proposed refinement to the ASP calculation. Nearly all of these commenters opposed this proposal and many asked for clarification of the proposed terminology.

All but one of the comments received from drug manufacturers stated that the proposed change to the ASP calculation would require significant modifications to manufacturers' accounting and reporting data systems while resulting in minimal change or benefit to the ASP-based payment. Many commenters stated that the proposed modification to the ASP calculation would not result in more accurate payments. Further, comments from groups representing drug and biological manufacturers stated that they do not believe the proposed methodology will have a material impact on the overall ASP or the accuracy of the calculation. Many of the commenters opposing the proposal stated that the expense and burden of implementing the proposed change to the ASP calculation would be unjustified because direct and indirect sales and price concessions for a given product are stable over time, particularly for generic products, and further breakdown of the calculation would not have a significant impact on the ASP calculation. Many commenters also noted that implementing the proposed weighted average approach would increase both the complexity of the ASP calculation and the potential for calculation error.

We received comments from manufacturers of oncology, inhalation, contrast media, and other drugs and biologicals that included estimates of the potential impacts of the proposed

modification to the ASP calculation for a limited number of NDCs chosen as examples. These estimates ranged from a slight decrease (less than one half of a percent) to a 4.3 percent increase in the overall ASP for the NDC. One manufacturer estimated that sales would have to vary 20 percent from the 12-month lag period to change the ASP by more than 1 percent. Notwithstanding the potential change in the overall ASP, all but one manufacturer, which reports ASP for a single product, recommended that we not adopt the proposed change. However, some of these commenters suggested that the weighted average approach be voluntary or applicable only in cases where significant fluctuations exist in the proportion of sales that are direct and indirect and there is a compelling need to apply the proposed methodology. Other commenters from the manufacturing community were concerned about consistency across manufacturers and recommended that we not leave it up to each manufacturer to choose whether to use the proposed methodology or not. One commenter suggested that the proposed methodology be mandatory for a manufacturer that has at least one NDC with direct sales of 33 percent or more of gross sales for the prior year. The manufacturer would then be required to calculate the ASP for all of its NDCs using the proposed methodology.

Several commenters expressed concern that the proposed definitions of direct and indirect sales were unclear and required further clarification to ensure consistent application across manufacturers. Several commenters noted that our use of the term supplier was confusing; that it was unclear whether GPO sales would be considered direct or indirect; and it was unclear how utilization rebates to PBMs should be categorized. Several commenters noted that certain purchasers (for example, specialty pharmacies) may purchase both directly and indirectly during a given reporting period. Similarly, we received a comment from a drug manufacturer requesting greater clarification on how to allocate price concessions across direct and indirect sales when a customer purchases under both of these channels. Several manufacturers noted that their current data systems were not capable of capturing data at the level of detail necessary to accurately segregate sales into the direct and indirect categories. Other commenters noted that, in general, manufacturers do not track price concessions associated with direct or indirect sales. As a result, several commenters recommended that, if the proposed methodology is adopted, we implement the change prospectively to allow for a phase-in period and to delay implementation until April 2006 or later to provide time for systems changes to be implemented and tested.

We received a few comments from drug manufacturers expressing their belief that other market issues cause fluctuation in the ASP, and that it would be more beneficial to receive guidance on how to resolve these issues.

A few commenters were concerned with the time frame for implementation of the proposed modification of the ASP calculation. These commenters recommended that we consider delaying implementation until after a trial period or at least until April 2006.

We also received comments from providers who have experienced difficulty acquiring drugs at or below the payment amount. These commenters, as well as comments from physician organizations, support changes to the ASP calculation insofar as they will result in more appropriate reimbursements for Part B drugs.

Response: Our goal is to ensure continued beneficiary access to care through implementation of accurate and sufficient payment systems. To this end, we proposed to refine the ASP calculation because the weighted average of direct sales ASP and indirect sales ASP could potentially improve the overall accuracy of the ASP calculation. We greatly appreciate the efforts undertaken by commenters to examine the potential impacts of the proposed method on the overall ASP calculation. Based on the comments received, we find compelling the commenters' concerns about the challenges and increased burden associated with calculating the ASP independently for direct and indirect sales and then calculating the weighted average ASP. Although we continue to have interest in the potential impacts of quarter to quarter variations in estimates of price concessions, we will not adopt the proposed change at this time.

In reaching our decision, we noted that all of the drug manufacturers that submitted comments reported that the impact of the proposed refinement of the ASP calculation would be minimal or not material. We note that these commenters are in a position to assess the impacts of the proposed methodology on their customers and to weigh the potential benefits and burdens inherent with the proposed change. In all but one case (a manufacturer which reports ASP for only one product), they did not support the proposal because they believe the burden would outweigh the benefit.

Among the comments received that specified potential percentage changes in the overall ASP, a range of potential impacts was reported. One of the examples submitted suggested that the impact could extend to upwards of a 4 percent increase in the ASP for an NDC, while another example showed a slight decrease. We cannot determine whether the reported examples are representative of other or all NDCs subject to the ASP reporting requirements.

We also noted the concerns expressed by manufacturers regarding the significant additional burdens associated with the proposed methodology, the potential for inconsistent application of the proposed methodology across manufacturers, and the potential effects of the proposed methodology on manufacturers' systems. In addition, we carefully considered the comments from the physician community in support of refinements to the ASP calculation that would increase payments.

Although we are not implementing the proposed refinement to the ASP calculation at this time, we will continue to work with manufacturer to better understand the instances in which the proposed methodology may benefit the program and the potential for appropriate use of that methodology for certain or all NDCs, and whether such an approach would be sustainable.

We did not receive any comments on our proposal to revise the regulations at § 414.804 to clarify that the estimation ratio methodology published on September 16, 2004 (69 FR 55763), relates to lagged price concessions; therefore, we will implement the revised regulatory language as proposed.

c. Determining the Payment Amount Based on ASP Data

As explained in the August 8, 2005 proposed rule (70 FR 45844) in response to inquiries we have received related to the formula we use to calculate the payment amount for each billing code we posted information on our web site (*http://www.questions.cms.hhs.gov*) earlier this year. We included this information (which follows) in the proposed rule to ensure greater public access to this information.

- For each billing code, we calculate a weighted ASP using the ASP data submitted by manufacturers.
- Manufacturers submit ASP data at the 11-digit NDC level.
- Manufacturers submit the number of units of the 11-digit NDC sold and the ASP for those units.

• We convert the manufacturers' ASP for each NDC into the ASP per billing unit by dividing the manufacturer's ASP for that NDC by the number of billing units in that NDC. For example, a manufacturer sells a box of 4 vials of a drug. Each vial contains 20 milligrams (mg). The billing code is per 10 mg. The conversion formula is: manufacturer's ASP/[(4 vials × 20 mg)/10 mg = 8 billable units per NDC].

• Then, the ASP per billing unit and the number of units (11-digit NDCs) sold for each NDC assigned to the Billing Code are used to calculate a weighted ASP for the billing code. We sum the ASP per billing unit times the number of 11-digit NDCs sold for each NDC assigned to the billing code, and then divide by the total number of NDCs sold. The ASP per billing unit for each NDC is weighted equally regardless of package size.

Comment: Several manufacturers and other commenters representing the manufacturing community recommended that the formula be revised so that the payment limit is calculated based on the weighted ASP of the number of billing units sold rather than the number of NDCs sold. These commenters noted that products are available in different package sizes and that a billing code may encompass multiple NDCs. As a result, these commenters contend that weighting the ASP payment amount by NDCs sold does not reflect the true weighted average price per billing unit. Several commenters, including manufacturers and their trade associations, noted that altering the formula to weight by the number of billing units sold may increase or decrease the overall ASP. Nonetheless, these commenters recommend adoption of their recommended alternative formula. One commenter suggested that the alternative formula be adopted along with an exception process that would be applicable to billing codes that represent therapies of differing weights or dosage. We also received comments from manufacturers that supported continued use of the current formula.

Response: In establishing the formula used to calculate the payment amounts based on the manufacturers' ASP data, we considered various approaches, including the alternative approach recommended by some commenters. For the initial implementation of the ASP methodology, we operationalized the calculation of ASP by weighting the formula by the number of NDCs sold. As we gain more experience with the ASP data and other sources of information become available about the purchasing patterns of providers and their acquisition costs, we may consider altering the methodology or establishing exceptions, if we find good reason to do so. If we decided such a change is warranted, we would implement the change at the next quarterly update.

Comment: Although not directly related to the formula used to calculate the ASP payment amounts, we received several comments from oncology physician practices and other commenters related to the adequacy of the ASP+6 percent payment methodology and other topics. We received several comments from oncology and other providers contending that the Medicare payment amount does not always cover their acquisition costs for certain drugs. A mid-sized oncology practice reported that it is unable to obtain nearly half of the drugs it administers at a price below the Medicare reimbursement rate. This commenter believes that larger practices may not face drug acquisition costs that exceed ASP+6 percent. One oncology practice reported that the ASP+6 percent payment would cover its drug costs if beneficiaries could always afford their cost sharing amounts. A large oncology practice stated that its average Medicare reimbursement, which is 2 percent more than its acquisition costs, was insufficient and would cause it to discontinue treatment for beneficiaries.

On the topic of price concessions, several commenters, including a drug manufacturer, suggested that prompt pay and other discounts given to wholesalers and distributors should not be included in the calculation of the manufacturers' ASP so that the payment amounts would be increased.

Response: It is true for all payment systems based on averages that the payment amount may not equal a specific provider's cost for every service. Section 1847A of the Act specifies that the Medicare payment is at 106 percent of ASP for the majority of Part B drugs and biologicals not paid on a cost or prospective payment basis. The statute requires use of the ASP+6 percent payment methodology except in limited instances. Although several commenters (most of which represent oncology practices) reported that the ASP+6 percent methodology was insufficient to cover their drug acquisition costs for certain drugs, these commenters also acknowledged that the Medicare payment exceeds their drug acquisition costs for other drugs. This is consistent with the findings of recent studies by the General Accountability Office (GAO) (GAO–05–142R), Office of Inspector General (OIG) (''Adequacy of Medicare Part B Drug Reimbursement to Physician Practices for the Treatment of Cancer Patients'', (A–06–05–00024), and MedPAC (October 6, 2005, public meeting report on oncology site visits). These studies have found that physicians generally can obtain oncology drugs for prices below Medicare reimbursement.

We did not propose a change to the price concessions manufacturers must include in the ASP calculation. Section 1847A(c)(3) of the Act specifically identifies prompt pay discounts as a type of price concession that must be included in the manufacturer's calculation of the ASP.

Comment: We received comments from a few drug manufacturers requesting clarification and more detailed guidance on the treatment of administrative fees, service fees, and data fees in the ASP calculation.

Response: These issues are beyond the scope of this rule. We will continue to work with manufacturers to more fully understand these issues. We expect to publish a final rule on the ASP reporting requirements and will consider these comments in the course of preparing that rule.

Comment: We received comments from oncology practices, ESRD facilities and retail pharmacies, as well as IVIG manufacturers and stakeholders, indicating that manufacturer price increases are not reflected timely in the ASP+6 percent payment amounts due to the necessary lag time for calculating the rates and updating the payment systems. One commenter suggested that we implement a ''true up'' mechanism that immediately reconciles the historic reimbursement rate to reflect manufacturer price increases. Several IVIG stakeholders suggested that we issue payment rates on a retroactive basis.

Response: Section 1847A(c)(5)(B) specifies a prospective update in the payment amounts. We agree with the commenters' observations that there is a necessary time frame after the close of a calendar quarter for manufacturers to calculate and submit the ASP data to CMS, for CMS to prepare and issue the payment rates, and for the claims processing contractors to implement the updated payment files. As we stated in the CY 2005 final rule (69 FR 66300), we implement these new prices through program instructions or otherwise at the first opportunity after we receive the data, which is the calendar quarter after receipt.

Comment: Several commenters, including patient and industry representatives and physicians as well as manufacturers, requested that we take steps to improve the availability of IVIG. Many of these commenters noted their

ongoing collaboration with the Congress, HHS, CMS and others to better understand the market forces and dynamics influencing the current IVIG situation. These commenters reported that numerous patients and physician practices have been adversely impacted by the change in reimbursement to the ASP+6 percent methodology. These impacts include postponed infusions, increasing intervals between infusions, having to receive treatment in the hospital setting rather than in the physician office, possible unintended reactions as a result of switching brands of IVIG, and increased level of effort to obtain product and schedule services. Several commenters restated suggestions previously communicated to us, including concerns about our proposed changes for IVIG reimbursement in the outpatient setting. Comments from an industry group referenced its new study that it is conducting to help clarify the marketplace and provide insight into the costs for providing IVIG services. The study will examine IVIG acquisition costs and related services. Citing the adverse effects of patients migrating from physician offices to hospitals for treatment, several commenters requested that we consider an interim add-on payment for the complex activities related to furnishing IVIG until the industry study is completed. These commenters noted that the add-on payment would ensure that providers are paid sufficiently for IVIG under Part B so that their provision of IVIG remains viable and beneficiaries' access to IVIG is not reduced.

Response: We will continue to work with the IVIG community, manufacturers, the Congress, and other entities to seek better understanding of the supply and market issues influencing the current IVIG market. We look forward to learning of the industry's study findings as that work progresses. We have discussed the accuracy of the ASP data with the manufacturers and have been assured by these manufacturers that their ASPs have been developed in accordance with applicable guidance and that the resulting price reflects the current IVIG market in aggregate. At the same time, the IVIG manufacturers' association, the Plasma Protein Therapeutics Association, reports that the overall supply of IVIG is adequate and has improved in the past several months. However, based on the comments received and our ongoing work with manufacturers, patient groups, and other stakeholders, we continue to be concerned about reports of patients experiencing difficulties in accessing timely IVIG treatments and reports of providers experiencing difficulties in obtaining adequate amounts of IVIG products on a consistent basis to meet their patients' needs in the current marketplace. Most brands of IVIG have been put on allocation by manufacturers and some manufacturers have reported allocating products to a smaller number of distributors and reducing the size of inventories. In addition, there have been reports of diversion of products to the secondary market and secondary distributors raising prices markedly. The Secretary's Advisory Committee on Blood Safety and Availability has recommended immediate steps be taken to ensure access to IVIG so that patients' needs are being met. However, the complexity of the IVIG marketplace makes it unclear what particular systematic approaches would be most effective in addressing the many individual circumstances that have been shared with us while not exacerbating what appears to be a temporary disruption in the marketplace.

IVIG is a complicated biological product that is purified from human plasma obtained from human plasma donors. Its purification is a complex process that occurs along a very long timeline, and only a small number of manufacturers provide commercially available products. Historically, numerous factors, including decreased manufacturing capacity, increased usage, more sophisticated processing steps, and low demand for byproducts from IVIG fractionation have affected the supply of IVIG. For CY 2006, there are 2 HCPCS codes that describe all IVIG products, based on their lyophilized versus liquid preparation.

The recent patterns of utilization of IVIG also are unusual in comparison with most other drugs and biologicals. Different IVIG products are FDA-approved in a number of therapeutic areas for various specific conditions which include: anti-infective therapy (bone marrow transplant); immune globulin replacement therapy (primary immune deficiencies and chronic lymphocytic leukemia); anti-inflammatory therapy (Kawasaki disease); and immunomodulation therapy (idiopathic thrombocytopenic purpura). IVIG therapy, which has been available for about 25 years, was initially reserved for the treatment of these FDA-approved indications. More recently, IVIG has been increasingly used off-label so that off-label uses now significantly exceed on-label uses. Many of these off-label uses are for autoimmune, neurological, or systemic inflammatory conditions. Some off-label uses of IVIG are supported by a robust evidence base, while for other medical conditions the evidence has not demonstrated that IVIG infusions are of significant therapeutic benefit. There are also new emerging indications for IVIG treatment, including those based on recommendations from various professional associations and advisory groups. In addition, despite the growing uses of IVIG there are definite risks associated with IVIG treatment, including both early inflammatory reactions and more rare but serious renal and thromboembolic complications, as well as the inherent risk associated with receipt of any biological product even with the ongoing improvements in the safety of these types of products.

Medicare currently has one national coverage determination in place since CY 2002 regarding IVIG infusions to treat autoimmune blistering diseases, and there are numerous local coverage policies that describe Medicare coverage for specific off-label indications. In the context of these national and local coverage policies, IVIG use in hospital outpatient departments has climbed steeply over the most recent years for which data are available, from about 40,000 infusion days in CY 2002, to 60,000 days in CY 2003, and again to over 70,000 days in CY 2004. The infusion of IVIG in physician offices increased from about 2.3 million grams in CY 2003 to 4.0 million grams in CY 2004. In the face of growing demand for IVIG in the absence of significant changes in the prevalence of medical conditions for which there is high quality evidence regarding the effectiveness of IVIG therapy, we are concerned that all patients with medical need for IVIG continue to have access to this expensive and valuable therapy. Over the upcoming year, we will be using our historical claims databases to study the epidemiology of IVIG treatment of Medicare beneficiaries in outpatient settings. We expect that the health system as a whole should encourage an accountable and scientifically-grounded use of IVIG, and we welcome discussions with industry, providers, and other interested entities regarding efforts to ensure that IVIG is responsibly utilized for evidence-based clinical indications so that optimal benefit is obtained.

Commenters have indicated to us that the infusion of IVIG in physician offices is more complex and resource intensive, particularly during the actual infusion, than many other types of infusions currently reported using the same drug administration CPT codes. They have described the specific resources

required for initiating and monitoring infusions of IVIG for patients under various clinical circumstances. We encourage commenters to discuss their concerns with the CPT Editorial Panel to assess whether alternative coding or additional CPT guidance would be appropriate. In addition, they may wish to discuss their resource concerns with the AMA/Specialty Society RVS Update Committee that provides advice regarding the resources associated with physician services.

Based on the potential access concerns, the growing demand for IVIG, and the unique features of IVIG detailed above, as we seek to gain improved understanding of the contemporary volatile IVIG marketplace, we will employ a two-pronged approach during CY 2006 to help ensure the availability of IVIG to physicians and hospital outpatient departments who care for Medicare beneficiaries and will be paid ASP+6 percent for the IVIG products.

First, in addition to the ongoing monitoring and outreach activities within the HHS, the Office of the Inspector General (OIG) is studying the availability and pricing of IVIG as part of its monitoring of market prices pursuant to section 1847A(d)(2)(A) of the Act. We expect the OIG's work to provide a significant contribution to the analysis of the current situation with respect to the specific activities of manufacturers and distributors that may be contributing to possible access problems for IVIG as we move to the ASP methodology in both physician office and hospital outpatient settings. We hope to understand those particular market behaviors that may have led to such public alarm about the availability of IVIG and the adequacy of our payment rate of ASP+6 percent, concerns that have been particularly strong and persistent for IVIG in comparison with other drugs paid under the same ASP methodology.

Second, we will provide additional payment in CY 2006. Presently the IVIG marketplace is a dynamic one, where a significant portion of IVIG products previously available in CY 2005 are being discontinued and other products are expected to enter the market over the next year. In light of this temporary market instability, we understand that manufacturers have continued allocation procedures aimed at stabilizing the supply of IVIG. Even so, we understand that providers may face purchasing whichever brand of IVIG is available, even if it is not a brand the patient is known to tolerate. Many patients treated with IVIG receive regular infusions on a predictable schedule. To meet this need, physicians' office staff must conduct significant preadministration services prior to IVIG infusions to monitor and manage their inventory, locate available IVIG products, reschedule infusions according to product availability and patients' needs, and implement physicians' determinations regarding whether the available formulations are appropriate for patients and whether specific dosing adjustments are required. Product-specific factors must be evaluated in light of patients' clinical indications for the IVIG infusions, their underlying medical conditions, and their past reactions to various IVIG products, and office staff must locate appropriate doses of IVIG products in light of these considerations. If the appropriate IVIG product formulations were more widely and reliably available, we do not believe that routine IVIG infusions would require these extensive preadministration-related services prior to each infusion.

To continue to ensure appropriate patient access to IVIG in CY 2006 during this short-term period of market instability for IVIG, beginning for dates of service on or after January 1, 2006 through December 31, 2006, we will temporarily allow a separate payment to physicians to reflect the substantial additional resources that are associated with locating and acquiring adequate IVIG product and preparing for an office infusion of IVIG in the current environment. We expect that making separate payment for these additional necessary services will help insure that physicians are able to continue to provide IVIG infusions to their patients who depend upon them. We will also provide an additional payment to hospital outpatient departments for these special services, to ensure that patients continue to have access to IVIG infusions in the most medically appropriate settings, without undesirable shifts in sites of service for their care.

Because the resources associated with the preadministration-related services for intravenous infusion of immunoglobulin are not accounted for in the physician office practice expense associated with the CY 2006 drug administration codes that will be billed for IVIG infusions, we are creating a temporary G-code to describe these additional preadministration services related to the intravenous infusion of immunoglobulin. We have established the following G-code for physician office billing for CY 2006:

G0332; *Preadministration-related services for intravenous infusion of immunoglobulin, per infusion encounter (This service is to be billed in conjunction with administration of immunoglobulin).*

Physicians may bill this service once per day in association with a patient encounter for administration of IVIG, in addition to billing for the appropriate drug administration service(s) and for appropriate units of the HCPCS code that describes the IVIG product infused. In addition, physicians may also bill for any significant and separately identifiable evaluation and management (E/M) service they perform at a level 2 through 5 in association with the infusion encounter, appending modifier –25 to the E/M service. We have established the payment level for this service in physician offices by cross-walking the RVUs for the new G-code to the practice expense RVUs of 1.90 for G0319, ESRD related services during the course of treatment, for patients 20 years of age and over; with 1 face-to-face physician visit per month. We do not believe there is increased preadministration physician work associated with preparation for intravenous infusion of immunoglobulin, so we have not allocated the physician work RVUs assigned to G0319 to G0332. Physician work associated with preparation for the intravenous infusion of immunoglobulin is already included in the physician work allocated to the drug administration services associated with the infusion and to the evaluation and management services (including the pre- and post-work already included in the relative values for evaluation and management services) provided to patients receiving intravenous immunoglobulin treatments. However, we think G0332 requires additional resources from the physician practice, particularly clinical labor, that are comparable to the practice expense for the ESRD management code. We expect that in many cases IVIG infusions will be provided once per month, with activities in preparation for the infusion, including consulting with patients and distributors, conducted over the course of a month as are the ESRD related services described by G0319. In addition, preparation for the IVIG infusion will generally not require a face-to-face visit with the patient prior to the infusion, so we have selected the ESRD related services G code that includes only one physician visit for the practice expense crosswalk.

We believe that this temporary separate payment provided through G0332 in CY 2006 for the physician office and hospital outpatient resources associated with additional IVIG preadministration-related services due to the present significant fluctuations in

the IVIG marketplace will ensure that Medicare beneficiaries depending on IVIG experience no adverse health consequences from the market instability for IVIG products. In the meantime, we will continue to evaluate the market factors affecting the pricing and availability of IVIG products in the context of our ASP+6 percent payment methodology and our separate payment for G0332 in CY 2006. We expect that in CY 2006 with continued collection of updated ASP data for IVIG; improved understanding of the IVIG marketplace; more focused attention on the medical necessity of the utilization of IVIG; ongoing collaboration between CMS, the IVIG community, manufacturers, providers, and other interested entities; and this temporary separate payment for hospital and physician office resources required for the intensive preadministration services related to IVIG infusion, the IVIG marketplace should stabilize over the upcoming year. Substantial preadministration-related services for IVIG infusions should no longer be required of physician offices and hospital outpatient departments that provide IVIG infusions to patients who need them. Therefore, this additional payment for G0332 is effective for CY 2006 only. Thus, we will be closely monitoring this issue once again in the context of our rulemaking for CY 2007.

Comment: Several commenters representing providers of community cancer care and manufacturers noted that physicians do not receive separate payment for pharmaceutical management and related pharmacy and handling costs (such as drug inventory, disposal of toxic waste, and spillage and breakage), and that in the 2006 proposed rule for HOPD we proposed a 2 percent add-on payment to the ASP+6 percent payment for drugs. These commenters stated the costs for handling pharmaceuticals are similar across settings and that physicians should receive the same add-on.

Response: The costs for handling pharmaceuticals are paid through the PE RVUs for the drug administration code.

d. Reporting WAC

As explained in the August 8, 2005 proposed rule (70 FR 45844) we have provided information on our web site (*http://www.questions.cms.hhs.gov*) concerning reporting WAC. We state that manufacturers must report the WAC for a single source drug or biological if it is less than the ASP for a quarter and in cases where the ASP during the first quarter of sales is unavailable. Upon further review, we have determined that the WAC must be reported each quarter if required for payment to be made under section 1847A of the Act, in addition to the ASP, if available.

Section 1927(b)(3)(A)(iii) of the Act specifies the ASP data manufacturers must report. Section 1927(b)(3)(A)(iii)(II) of the Act specifies that the manufacturer must report the WAC, if it is required in order for payment to be made under section 1847A of the Act. Under section 1847A of the Act, the payment is based on WAC (as opposed to ASP) in the following cases:

- For a single source drug or biological, when the WAC-based calculated payment is less than the ASP-based calculated payment for all NDCs assigned to such drug or biological product. (*See* section 1847A(b)(4) of the Act.)
- During an initial period in which data on the prices for sales for the drug or biological is not sufficiently available from the manufacturer to compute an ASP. (*See* section 1847A(c)(4) of the Act.)

In these instances, we must make the determination of whether the payment amount is based on ASP or WAC. Therefore, WAC is required for payment in all of these instances.

As explained in the August 8, 2005 proposed rule (70 FR 45844), we had previously published a template which manufacturers must use to report ASP data to us; however, the WAC was not included in that template. Therefore, because of the requirement to report the WAC and the confusion manufacturers have experienced in submitting the WAC data we proposed, in a separate information collection notice published August 19, 2005 (70 FR 48770), to revise the reporting template to include a place to report WAC.

To clarify the instances when manufacturers are required to report the WAC, in the August 8, 2005 proposed rule (70 FR 45844), we stated that manufacturers are required to report quarterly both the ASP and the WAC for NDCs assigned to a single source drug or biological billing code. Manufacturers are also required to report the WAC for use in determining the payment during the initial period under section 1847A(c)(4) of the Act. That is, the WAC is reported for the reporting period prior to reporting the ASP based on a full quarter of sales.

Because the WAC could change during a reporting period, we proposed that in reporting the WAC, manufacturers would be required to report the WAC in effect on the last day of the reporting period.

Comment: Some commenters noted that requiring manufacturers to report WAC for all single source drugs each quarter encompasses the requirement for manufacturers to report WAC for new drugs during the initial period. Separately specifying these instances in the preamble led some commenters to request clarification of how the proposed policy differs from the existing requirements posted on our web site. Several manufacturers requested that we clarify in the final rule with comment that the WAC in effect on the last day of the reporting period is the value to be submitted for that reporting period.

Response: We agree with the commenters who noted that new drugs are a subset of single source drugs. We separately specified the requirements for reporting WAC in these two instances so that manufacturers would be aware of the reporting requirement and because we have discussed these instances separately in past rulemaking.

The proposed change is different from existing guidance previously posted on our web site in that we clarify that submission of the WAC in these instances is always necessary for payment to be made. The manufacturer does not decide if the WAC is to be submitted and the WAC is not submitted only if it is less than the ASP as previously posted on our web site. We interpret section 1927(b)(3)(A)(iii)(II) of the Act to apply to all NDCs of single source drugs.

Final Decision

Manufacturers must report WAC for all single source drugs (including new drugs) each reporting period. In submitting the WAC, manufacturers must report the WAC in effect on the last day of the reporting period. We will update our web site to include this decision.

e. Revised Format for Submitting ASP Data

The August 8, 2005 proposed rule (70 FR 45845) included a discussion of the format manufacturers are required to use to report the ASP data to us. However, as discussed above, the current template does not provide adequate instructions for manufacturers to report both the ASP and the WAC. Therefore, we published a separate information collection notice on August 19, 2005 (70 FR 48770) and proposed to revise the ASP reporting format to accommodate submission of both, the ASP and the WAC as well as collect the following additional information:

- Drug name.

• Package size (strength of product, volume per item, and number of items per NDC).

• Expiration date for last lot manufactured.

• Date the NDC was first marketed (for products first marketed on or after October 1, 2005).

• Date of first sale for products first sold on or after October 1, 2005.

Comment: We received several comments in response to the proposed rule related to our separate information collection notice on the proposed changes to the ASP reporting format (CMS–10110; see 70 FR 48770). The commenters generally supported inclusion of the WAC and drug name within the reporting format. Some commenters expressed concerns related to the level of burden that would be necessary to report some of the proposed additional data elements, particularly the date the NDC was first marketed. Some commenters suggested refinements to the definitions of the proposed data elements and the frequency of their collection. In addition, commenters suggested that we consider using data elements collected by Medicaid in lieu of the proposed data elements pertaining to first marketing date, first date of sale, and expiration date. In addition, commenters stated that they were uncertain when the proposed changes to the reporting requirements would be effective.

Response: We appreciate receiving the comments on the proposed additional data elements and the proposed revisions to Addendum A used to report ASP data. To be considered timely, comments on the proposed modification to ASP reporting format must have been mailed within 60 days of that notice (by October 18, 2005). All timely comments were not available for consideration at the time of the preparation of this final rule with comment. Changes to the ASP information collection (CMS–10110; OMB control number 0938–0921), if adopted by CMS and approved by the OMB, would be effective as of the approval date of the information collection submission Manufacturers would begin reporting the additional data elements with the next reporting deadline.

f. Limitations on ASP

Section 1847A(d)(1) of the Act states that ''the Inspector General of HHS shall conduct studies, which may include surveys to determine the widely available market prices (WAMP) of drugs and biologicals to which this section applies, as the Inspector General, in consultation with the Secretary determines to be appropriate.'' Section 1847A(d)(2) of the Act states that ''Based upon such studies and other data for drugs and biologicals, the Inspector General shall compare the ASP under this section for drugs and biologicals with—

• The widely available market price (WAMP) for these drugs and biologicals (if any); and

• The average manufacturer price (AMP) (as determined under section 1927(k)(1) of the Act for such drugs and biologicals.''

Section 1847A(d)(3)(A) of the Act states that ''The Secretary may disregard the ASP for a drug or biological that exceeds the WAMP or the AMP for such drug or biological by the applicable threshold percentage (as defined in subparagraph (B)).'' The applicable threshold is specified as 5 percent for CY 2005. For CY 2006 and subsequent years, section 1847A(d)(3)(B) of the Act establishes that the applicable threshold is ''the percentage applied under this subparagraph subject to such adjustment as the Secretary may specify for the WAMP or the AMP, or both.''

For CY 2006, we proposed to specify an applicable threshold percentage of 5 percent for both the WAMP and AMP. We did not receive the OIG's final report in time for consideration before developing the proposed rule. Thus, we believe that continuing the CY 2005 threshold percentage applicable to both the WAMP and AMP is most appropriate.

Comment: One commenter stated its support of credible drug rates that are based upon widely accepted health care industry standards, and that are established using methodologies that are clear and readily understood by persons with health care industry knowledge. In this context, the commenter expressed concern about how well the terms WAMP and AMP are understood across the health care industry. Several commenters supported our proposal to retain 5 percent as the applicable threshold for 2006, while strongly urging that we not implement the provisions relating to substitution of the ASP until notice and comment rulemaking is conducted. Many commenters referred to the language in the Conference Report accompanying the MMA that discusses rulemaking in connection with this issue and requested that we follow the intent of that language and provide the public the opportunity to evaluate the validity of the processes used and the data obtained by OIG.

Response: We appreciate the commenter's acknowledgement that we are required to specify the threshold percentage applicable in 2006. Section 1847A(d)(3)(B)(i) of the Act specified the applicable threshold percentage for 2005. Section 1847A(d)(1) of the Act requires that the OIG conduct studies to determine the WAMPs, and the OIG began its study activities shortly after the passage of the MMA. Upon completion, the OIG's findings and methodology will be available to the public. We are aware of the Conference Report language; however, given the statutory requirements in section 1847A(d), we do not believe rulemaking is appropriate at this time.

Final Decision

We will establish 5 percent as the applicable threshold for 2006.

2. Payment for Drugs Furnished During CY 2006 in Connection With the Furnishing of Renal Dialysis Services if Separately Billed by Renal Dialysis Facilities

Section 1881(b)(13)(A)(iii) of the Act indicates that payment for a drug furnished during CY 2006 and subsequent years in connection with the furnishing of renal dialysis services, if separately billed by renal dialysis facilities, will be based on the acquisition cost of the drug as determined by the OIG report to the Secretary as required by section 623(c) of the MMA or, the amount determined under section 1847A of the Act for the drug, as the Secretary may specify. In the report entitled, ''Medicare Reimbursement for Existing End Stage Renal Disease Drugs,'' the OIG obtained the drug acquisition costs for the top 10 ESRD drugs for the 4 largest ESRD chains as well as a sampling of the remaining independent facilities. Based on the information obtained from this report, for CY 2005, payment for the top 10 ESRD drugs billed by freestanding facilities and payment for EPO billed by hospital-based facilities was based on acquisition costs as determined by the OIG. Due to the lag in the data obtained by the OIG, we updated the acquisition costs for the top 10 ESRD drugs to 2005 by the PPI. The separately billable ESRD drugs not contained in the OIG report were paid at the ASP+6 percent for freestanding facilities. The payment allowances for these remaining drugs were updated on a quarterly basis during 2005.

Section 1881(b)(13)(A)(iii) of the Act gives the Secretary the authority to establish the payment amounts for separately billable ESRD drugs beginning in 2006 based on acquisition costs or the amount determined under section 1847A of the Act. As discussed in the proposed rule, we do not believe that it is appropriate to continue to use

2002 acquisition costs updated by the PPI for another year as the basis for payment. The acquisition costs are based on 2002 data which, despite updates by the PPI do not necessarily reflect current market conditions. Thus, the chances increase that Medicare payments will either overpay or underpay for drugs resulting in payments that are inconsistent with the goal of making accurate payments for drugs. We also considered whether actual acquisition cost data could be periodically updated. However, we do not believe that it would be feasible to base Medicare payments over the long term on continually acquiring data on actual acquisition costs from ESRD facilities. This approach would provide incentives for manufacturers and facilities to increase acquisition costs without constraint. It also would not necessarily provide data regarding current market rates. Therefore, we proposed that the payment methodology for all ESRD drugs when separately billed by freestanding ESRD facilities during CY 2006 be the amount determined under section 1847A of the Act. This payment amount is the ASP+6 percent rate.

Based on an analysis of the 2002 acquisition costs for the top 10 separately billable ESRD drugs, when updated by the PPI for CY 2006, it is our contention that relying on 2002 acquisition cost data updated for a number of years as would be necessary to establish a payment amount for 2006 is not the most appropriate option for determining Medicare payment rates when other drug-specific pricing is available. Further, we contend that relying on the ASP+6 percent as the payment rate for all separately billable ESRD drugs when billed by freestanding ESRD facilities for CY 2006 is a more reliable indicator of the market transaction prices for these drugs. The ASP is reflective of manufacturer sales for specific drug products and is more indicative of market and sales trends for those specific products than the 2002 OIG acquisition cost data.

We also note MedPAC's recommendation in its June 2005 report that the ASP be the basis of payment for all separately billable ESRD drugs provided by both freestanding and hospital-based facilities in CY 2006 (MedPAC, ''Report to the Congress: Issues in a Modernized Medicare Program,'' June 2005). In making this recommendation, MedPAC states that the ASP data are more current (updated quarterly) and more likely to reflect actual transaction prices when compared with acquisition cost data which are not regularly collected by the OIG or CMS. Furthermore, the report indicated that utilizing the same payment policy for both freestanding and hospital-based facilities would ensure uniformity across the various settings irrespective of the site of care. In addition, MedPAC recommends in its report that we obtain, ''* * * data to estimate hospitals'' costs and Medicare's payment per unit for these drugs. No published source identifies the unit payment for these drugs because Medicare pays hospitals their reasonable costs.'' MedPAC further states: ''We attempted to calculate the unit payment from 2003 claims data, but the accuracy of the data fields we needed to make this calculation was unclear, particularly the number of units furnished and Medicare's payment to the hospital.'' MedPAC also recommends that CMS or the OIG collect acquisition cost data periodically in the future to gauge the appropriate percentage of ASP for the payment amount.

We acknowledged MedPAC's recommendations regarding uniformity across the various settings irrespective of the site of care and believe it is more appropriate to pay for separately billed drugs furnished in hospital-based facilities under the ASP+6 percent methodology rather than on a reasonable cost basis.

Therefore, for CY 2006, we proposed that payment for a drug furnished in connection with renal dialysis services and separately billed by freestanding renal dialysis facilities and EPO billed by hospital-based facilities be based on section 1847A of the Act. We proposed to update the payment allowances quarterly based on the ASP reported to us by drug manufacturers. We sought comment on our proposed decision to revise the payment methodology for separately billable ESRD drugs and about the potential method we have discussed in other sections of this final rule with comment which would permit us to pay hospital-based facilities under the ASP+6 percent methodology for 2006. We also sought comment on how this proposed decision could affect beneficiaries' or providers' access to these drugs.

We received numerous comments regarding our proposal to pay for drugs furnished in connection with renal dialysis services and separately billed by free-standing renal dialysis facilities as well as EPO billed by hospital-based facilities at the ASP+6 percent payment methodology. We also received comments on our proposal to continue to pay hospital-based facilities reasonable cost for separately billable ESRD drugs. Those comments and responses are provided below.

Comment: Several commenters agreed with our proposal to use the ASP+6 percent methodology as the basis for payment for drugs furnished in connection with renal dialysis services and separately billed by free-standing renal dialysis facilities as well as EPO billed by hospital-based facilities and our decision to update the payment allowances on a quarterly basis. These commenters viewed the ASP+6 percent payment methodology as superior to the average acquisition payment methodology as the ASP+6 percent methodology enables payment to reflect the actual market transaction prices for ESRD drugs. Commenters stated that reliance on the ASP+6 percent methodology will lead to a more uniform payment policy across care settings. These commenters strongly recommended that we finalize our proposal to pay all ESRD drugs when separately billed by freestanding ESRD facilities, as well as EPO when furnished in hospital-based facilities at ASP+6 percent. It was noted that the ASP+6 percent methodology is easier for us to administer as we already collect and update ASP data on a quarterly basis. Other commenters were cautious in regards to the ASP system, indicating that although the shift from average acquisition cost to ASP+6 percent appeared rational, the ASP would be largely influenced by the lower large provider price. As a result, the ASP prices would not reflect the acquisition costs for all providers. Small dialysis facilities would be unable to purchase ESRD drugs at the proposed prices and would be at risk of being paid well below their acquisition costs, as they lack the same buying power or economics of scale that larger facilities possess. Some commenters focused on statements we made in the past in which we stated that we expected smaller providers to join buying groups in order to reduce acquisition costs. These commenters stated that although almost all small dialysis providers belong to such buying groups, such arrangements have not reduced the disparity between the large providers' acquisition prices and the small providers' acquisition prices. Commenters suggested that this ''market dynamic'' with extremely different buying power among providers does not exist in any other market where we have established drug payment policies.

Response: We agree with the commenters who suggested that we establish the 2006 payment rates for drug furnished in connection with renal dialysis services and separately billed

by freestanding renal dialysis facilities and EPO billed by hospital-based facilities using the ASP, rather than use the 2002 average acquisition costs updated by the PPI. We also agree for 2006 to apply the quarterly update of ASP data to payment for drugs furnished by freestanding renal dialysis facilities and EPO billed by hospital-based facilities.

After consideration of the feasibility of continuing to use 2002 acquisition costs updated by the PPI for another year, we have determined that the ASP+6 percent methodology is the most accurate measure for paying for EPO furnished in hospital-based facilities and for separately billable ESRD drugs provided in freestanding dialysis facilities.

Implemented in 2005 by the MMA of 2003, the ASP methodology is based on data submitted by manufacturers of Medicare Part B drugs. The ASP for all drug products included within the same billing and payment code is the volume-weighted average of the manufacturers' ASPs reported to us across all the NDCs assigned to the billing or payment code. Therefore, the ASP is a more accurate indicator of market trends for specific drugs.

We do not agree with commenters who suggest that varying buying power only exists among providers of ESRD drugs. Other purchasers of Part B drugs have expressed concerns to us regarding a variation in buying power. We will continue to support groups representing Medicare Part B drug purchasers, especially small and rural purchasers, to help them identify the most favorable drug prices possible.

Comment: Many commenters requested that if we implemented the ASP-based methodology for separately billable ESRD drugs, we should utilize the most recently available ASP data and update that data quarterly. These commenters expressed concern about the significant lag time apparent in the current ASP methodology, indicating the lag time results in a decrease in payment that no dialysis facility has the ability to make up. Commenters encouraged us to provide retrospective payments to dialysis facilities, particularly small or independent dialysis providers to prevent such facilities from reducing services or from closing. One large drug manufacturer suggested that we consider an alternative drug payment option for small providers and we assure that these providers are not negatively affected by changes in the payment policy for drugs. Commenters suggested that we utilize a methodology that uses average acquisition price for small providers as the marker for ESRD drug reimbursement, citing section 1881(b)(13)(A)(ii) of the Act as the authority. Under this system, we would collect acquisition cost data from small providers, update the data for the current year and establish payment rates on these acquisition costs. Other commenters suggested that we consider establishing an exception process whereby rural or inner city ESRD facilities could request an alternate payment based on their actual drug acquisition costs as a result of unique economic circumstances. Some commenters suggested that we exclude EPO from the ASP payment methodology, stating that EPO has only one manufacturer and accounts for a large proportion of drug payment to independent dialysis facilities. Some commenters suggested that contracts of large providers are able to influence the ASP for EPO and for these providers; the acquisition price will be close to ASP. The inclusion of EPO in the ASP methodology will create disparity in patient care.

Response: In response to concerns regarding the significant lag time apparent in the ASP methodology, the ASP methodology is based on ASPs reported by manufacturers quarterly. Manufacturers must report to us no later than 30 days after the close of the quarter. We implement these new prices through program instructions or otherwise at the first opportunity after we receive the data, which is the calendar quarter after receipt.

We do not agree with commenters who suggested that we permit small, rural, or inner city ESRD facilities to request an alternate payment based on their actual drug acquisition costs, or that we exclude EPO from the ASP payment methodology. We do not have that authority. Section 1881(b)(13)(A)(iii) of the Social Security Act states that the Secretary chooses the methodology to determine payment rates for all drugs separately billed by ESRD facilities. The language refers to the choice of acquisition costs as determined by the Inspector General of the ASP rates. Section 1881(b)(13)(A)(ii) does not provide authority for individual providers to choose whether to be paid on the basis of costs or the ASP method.

Comment: Several organizations stated that payment differences should be eliminated for separately billable drugs furnished in independent and hospital-based facilities and the ASP payment methodology should be used for all drugs provided in hospital-based facilities. One commenter agreed with our concerns regarding the lack of available data from hospital claims and recommended that the Secretary collect data on the acquisition cost and payment per unit for drugs furnished by hospital-based providers, or consider using the unit dosing information obtained from claims submitted by freestanding dialysis facilities and consult with clinical experts regarding the appropriateness of the dose data.

Response: We agree with commenters who suggested that we utilize the same payment methodology for separately billable drugs furnished in independent facilities and hospital-based facilities. For reasons discussed in the ESRD section of this final rule with comment, we believe it is appropriate to implement the ASP payment methodology for all drugs provided in hospital-based facilities.

Comment: Prompt pay discounts are included in the calculation of the ASP; however, commenters stated that small customers do not normally receive such discounts. Rather, these customers are charged an additional service fee to the price of the product. Thus, by including prompt pay discounts in the calculation of the ASP, the ASP is lowered, but the small providers are not privy to such discounts. Commenter also stated that sales to cutomers outside of independent dialysis facilities are included in the calculation of the ASP and thus, contribute to the difference between manufacturer-provided ASPs and provider acquisition costs. They stated that we have established a distinct methodology for drug payment for hospital-based dialysis facilities, and therefore, it is inappropriate to include such customers in the ASP payment system for independent dialysis facilities.

Response: In the calculation of the ASP, as specified in Section 1847A(c)(3), a manufacturer should include volume discounts, prompt pay discounts, cash discounts, free goods that are contingent on any purchase requirements, chargebacks, and rebates (other than rebates under the Medicaid rebate statute). We lack the statutory authority to permit manufacturers to exclude prompt pay discounts from the calculation of the ASP. Further, the statute does not permit the exclusion of or differentiation by classes of trade in the calculation of the ASP payment rates, except for the specific statutory exceptions described in the Medicaid best price calculation under sections 1927(c)(1)(C)(i) and 1927(c)(1)(C)(ii)(III) of the Act.

Comment: Several commenters stated that the ASP methodology does not take into consideration provider costs for storage, handling, and wastage. Small

providers will be disadvantaged as they have less efficient and more costly systems for storage and handling.

Response: The ASP+6 percent payment methodology was not intended to cover the handling and storage of drugs.

3. Clotting Factor Furnishing Fee

Section 303(e)(1) of the MMA added section 1842(o)(5) of the Act which requires the Secretary, beginning in CY 2005, to pay a furnishing fee in an amount the Secretary determines to be appropriate to hemophilia treatment centers and homecare companies for the items and services associated with the furnishing of blood clotting factor. In the CY 2005 final rule (69 FR 66236), we established a furnishing fee of $0.14 per unit of clotting factor for CY 2005. Section 1842(o)(5) of the Act specifies that the furnishing fee for clotting factor for years after CY 2005 will be equal to the fee for the previous year increased by the percentage increase in the consumer price index (CPI) for medical care for the 12-month period ending with June of the previous year. The percent increase for the 12 months ending June 2005 is 4.2 percent. Consequently, the furnishing fee will be $0.146 per unit clotting factor for CY 2006. While the furnishing fee payment rate is calculated at 3 digits, the actual amount paid to providers and suppliers is rounded to 2 digits. The requests to publish the 2006 furnishing fee in the final rule with comment were the only comments we received on the clotting factor section in the proposed rule.

4. Payment for Inhalation Drugs and Dispensing Fee

Medicare Part B pays for inhalation drugs administered via a nebulizer, a covered item of DME. Beginning in CY 2006, coverage for inhalation drugs administered through metered dose inhalers will generally be available through the Medicare Part D benefit. This represents an important expansion in the options available to beneficiaries for inhalation drug coverage under Medicare. We expect that both modes of inhalation drug delivery will play an important role in the Medicare program in the years to come.

Prior to CY 2004, most Medicare Part B covered drugs, including inhalation drugs administered by a nebulizer (hereafter referred to as inhalation drugs), were paid at 95 percent of the AWP. Numerous studies by the OIG and GAO indicated that 95 percent of AWP substantially exceeded suppliers' acquisition costs for Medicare Part B drugs, particularly for the high volume inhalation drugs, albuterol and ipratropium bromide.[1] The MMA changed the Medicare payment methodology for many Part B covered drugs, including inhalation drugs. As an interim step, in CY 2004, Medicare paid a reduced percentage of AWP, 80 percent of AWP in the case of albuterol and ipratropium bromide. Beginning with CY 2005, Medicare paid for inhalation drugs at 106 percent of the average sales price (ASP+6 percent).

In addition to making payment for the drug itself, Medicare also pays a dispensing fee to suppliers of inhalation drugs. Prior to CY 2005, Medicare paid a monthly $5 dispensing fee for each covered inhalation drug or combination of drugs used. In the August 5, 2004 proposed rule (69 FR 47488), we sought comment on an appropriate dispensing fee level to cover the shipping, handling, compounding, and other pharmacy activities required to get these medications to beneficiaries. We received many comments asserting that a substantial fee was needed to compensate suppliers for a wide range of costs associated with dispensing drugs to beneficiaries, with many citing a 2004 report prepared by a consultant for the American Association for Homecare (AAH) that recommended a $68 fee.[2] The 2004 AAH report provided information for 10 cost categories: clinical intake; establishing/revising the plan of care; delivery of services; compliance monitoring/refill calls; billing/collections; other direct costs; patient education; caregiver training; care coordination; and in-home visits. In addition, as discussed in the August 8, 2005, proposed rule, a 2004 study by the GAO showed substantial variation in supplier costs of dispensing inhalation drugs.[3] With the wide variation in the reported costs and services provided by inhalation drug suppliers suggested by the comments and the GAO study, we stated in the CY 2005 final rule (69 FR 66338) that we would establish an interim dispensing fee for inhalation drugs applicable for CY 2005 and reconsider the issue for CY 2006. The 2005 dispensing fee for a 30-day supply of inhalation drugs was based on the industry recommended $68 fee from the 2004 AAH study, excluding certain costs that Medicare generally does not reimburse regardless of the Medicare Part B benefit category (that is, sales and marketing, bad debt, and an explicit profit margin). The resulting fee established for a 30-day supply of inhalation drugs was $57 for CY 2005. Because the 2004 AAH study did not establish a fee for a 90-day supply, we applied the methodology used in the 2004 GAO report to convert the 30-day fee to a 90-day fee. Accordingly, the 2005 fee established for a 90-day supply was $80. In establishing the dispensing fee rates for 2005, we indicated in the CY 2005 final rule that although the AAH study contained costs related to services that may be of potential benefit to our beneficiaries, we were concerned that these services may be outside the scope of a dispensing fee. We indicated that we would consider this issue further in order to establish an appropriate dispensing fee for CY 2006.

As discussed in the August 8, 2005 proposed rule (70 FR 45847), we indicated that we intend to establish a dispensing fee amount for 2006 that is appropriate to cover the costs of those services that fall within the scope of a dispensing fee. Furthermore, we indicated that we thought this fee amount likely would be lower than the current fee of $57 per 30-day period in 2005. In the proposed rule we solicited public comments and information on a number of issues including the following:

- What services appropriately fall within the scope of a dispensing fee; the cost of providing those services; and, whether any of the services being provided by inhalation drug suppliers may be covered through another part of the Medicare program, such as the PFS or the DME benefit.
- An appropriate dispensing fee level for 2006 as well as data and information on the various services inhalation drug suppliers are currently providing to Medicare beneficiaries and the associated costs, and typical dispensing costs for an efficient, high-quality supplier.
- The extent to which inhalation drug suppliers have utilized the newly available 90-day scripts in order to reduce unit shipping costs and any reasons as to why 90-day supplies may not have been utilized.
- How revised guidelines regarding the timeframe for delivery of refills has affected the need for overnight delivery services as well as the extent to which suppliers have shifted their shipping to ground services.
- Comments on the potential impact on beneficiaries and providers of possible changes to the inhalation drug dispensing fee in 2006, as well as the

[1] GAO, ''Medicare Payment for Covered Outpatient Drugs Exceed Providers' Costs,'' September 2001. OIG, ''Excessive Medicare Reimbursement for Albuterol,'' March 2002.

[2] Muse & Associates Report for the American Assoication for Homecare, ''The Cost of Delivering Inhalation Drug Services to Medicare Beneficiaries,'' August 2004.

[3] GAO, ''Appropriate Dispensing Fee Needed for Suppliers of Inhalation Therapy Drugs,'' GAO–050–72, October 2004.

impact of the new drug benefit on inhalation drug access.

Comment: Many commenters suggested that dispensing inhalation drugs to Medicare beneficiaries involves a wide range of services that should be compensated through the dispensing fee. A number of commenters referenced a 2005 report by an industry consultant sponsored by the AAH.[4] The 2005 AAH report indicated that suppliers provide services in seven broad categories: Intake; compounding, dispensing, and pharmacy assessment; delivery, set-up, and patient education; follow-up and compliance monitoring; quality assurance, accreditation, licensing, and regulatory compliance; Medicare billing and compliance; and other direct and indirect costs and expenses. Within these seven categories, the 2005 AAH report indicated that there were ''117 discrete services'' provided to or on behalf of Medicare beneficiaries. The 2005 report surveyed 82 homecare pharmacies. The vast majority of survey respondents thought the 117 discrete services outlined by the consultant fell within the scope of a dispensing fee, and the vast majority of respondents indicated they were providing these services. Several commenters suggested that the survey demonstrated there was widespread agreement that the standard of care for inhalation drug suppliers involved a wide range of services. In addition, one commenter asserted that the 117 services identified in the 2005 AAH report encompassed all of the functions identified in the 2004 AAH report prepared by the same consultant, which formed the basis of the 2005 fee.

Response: We established the interim dispensing fee for 2005 based on cost data from the 2004 AAH report. That report provided cost data for 10 service categories: Clinical intake; establishing/revising the plan of care; delivery of services; compliance monitoring/refill calls; billing/collections; other direct costs; patient education; caregiver training; care-coordination; and in-home visits. In using this data to establish the 2005 fee in the CY 2005 final rule, we indicated that we were concerned that some of the services in the industry cost data may be outside the scope of a dispensing fee and we would revisit this issue further in order to establish an appropriate dispensing fee for CY 2006. As discussed in the August 8, 2005, proposed rule, we continue to have concerns with respect to what services should be included within the dispensing fee payment.

Authority for a dispensing fee for inhalation drugs is based on section 1842(o)(2) of the Act, which provides that if payment is made to a licensed pharmacy for a drug or biological under Medicare Part B, the Secretary may pay a dispensing fee (less the applicable deductible and coinsurance) to the pharmacy. The statute did not define the term dispensing fee or set parameters as to what activities should be included within the scope of that definition. However, as discussed below, we do not believe the Congress intended us to adopt the broad reading of dispensing fee suggested by commenters.

We are not persuaded by suggestions that Medicare should broadly define the definition of dispensing fees for inhalation drugs to include pharmacy care management services such as patient education, caregiver training, care coordination, and in-home visits. A number of commenters suggested the dispensing fee be based on the total costs of supplying inhalation drugs indicated by the 2004 AAH report data. That data indicated that suppliers expend on average 63.5 minutes per new patient and 50 minutes per established patient per month on patient education, caregiver training, care coordination, and in-home visits. Such services represent pharmacy care management services, which (if included in dispensing fee payments) would extend the definition of dispensing fee beyond what we believe should be reasonably included within the scope this benefit. As an initial matter, we do not believe that there is any indication that the Congress intended these care management activities to be included in the definition of dispensing fees. Where the Congress wished for us to cover the costs of such training and management services under Medicare, it specifically directed us to do so (for example, by amending the statute to recognize diabetes outpatient self management training under Medicare Part B and medication therapy management programs under Medicare Part D (see sections 1861(qq) and 1860D–4(c) of the Social Security Act). Therefore, in accordance with our interpretation of the statute, we do not believe it is reasonable for us to define the term dispensing fee under Medicare Part B to include the costs of such services.

In addition, we also believe that the inclusion of beneficiary education and training about use of nebulizers would raise duplicate payment issues. Payment for DME is based on fee schedule amounts which include, in part, amounts for training beneficiaries on the use of nebulizer equipment. Thus, the equipment supplier is responsible for educating the beneficiary on the use of the DME or ensuring that ''another qualified party'' has done so as specified in § 424.57(c)(12). In addition, under the physician fee schedule Medicare makes a separate payment for beneficiary training by a physician or physician's staff regarding use of a nebulizer (CPT code 94664, demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device). We believe that physicians can play an important role in beneficiary training concerning the use of nebulizers, as they are ultimately responsible for directing beneficiary care, and determining what drug treatment regimen is most effective for an individual patient. Accordingly, because payment for education, training, and management concerning use of nebulizer equipment may be separately recognized under Medicare, we are concerned that the inclusion of such services within the definition of dispensing fee would increase the potential for double billing.

We are also not persuaded by commenters' suggestions that the 2005 AAH report demonstrates that the standard of care for supplying inhalation drugs includes a broad range of services. The 2005 AAH report presented results from a survey of homecare companies, in which the companies were asked whether 117 activities or overhead items should be included in the dispensing fee and whether the companies currently provide or undertake each activity/item (although the frequency and extent to which each activity/item was provided was not asked). The 2005 report identified services provided but failed to provide any information on the proportion of beneficiaries actually receiving various services (for example, patient education, caregiver training, in-home visits). It also did not provide any information on the cost of various services (other than delivery), or the amount of time involved in providing these services to the typical beneficiary. Consequently, the 2005 AAH report fails to demonstrate that the 117 activities/overhead items outlined in the 2005 report translate into an average of 63.5 minutes per new patient and 50 minutes per established patient each month for the care management services of patient education, caregiver training, in-home visits, and care coordination in the 2004 AAH report. Since the 2005 report did

[4] Muse Associates Report Prepared for the American Association for Homecare, ''Examination of Inhalation Drug Services to Medicare Beneficiaries Under the Average Sales Price Reimbursement Methodology In Response to the CMS Notice of Proposed Rule Making (CMS–1502–P),'' September 2005.

not include information on costs, the 2004 AAH report is the only information we have on average cost and time per activity. However, even the 2004 AAH report does not contain information on the proportion of beneficiaries that actually receive the care management services. Accordingly, given the data identified in the reports, we are not persuaded by the AAH reports that the standard of care for supplying inhalation drugs includes extensive care management services for patient education, caregiver training, in-home visits, and care coordination.

Furthermore, a September 2005 OIG study entitled ''Review of Services Provided by Inhalation Drug Suppliers'' [5] found little evidence that inhalation drug suppliers provide care management services to many beneficiaries. The OIG report sought to ascertain the nature and extent of services provided by inhalation drug suppliers. The OIG examined services such as clinical intake, revising the plan of care, patient/caregiver education, responding to patient/caregiver inquiries about the drug, contacting the physician's office, contacting a patient for a refill, reviewing medication compliance, and other certain services. The OIG did not focus on certain core activities such as filling prescriptions, delivery, and billing that they indicated were necessary for suppliers to dispense drugs and receive reimbursement. They also indicated that they excluded equipment related services because Medicare pays suppliers separately for equipment.

The OIG report concluded that beneficiaries receive few services from their inhalation drug supplier beyond calls to ask if they need a drug refill. The OIG report found that among beneficiaries with at least 2 months of claims in 2003, 16 percent received no services (that is, no educational services, refill calls, or other adjunct services the OIG examined) from their inhalation drug supplier during the entire year. The OIG found that refill calls accounted for the majority of services provided by inhalation drug suppliers. In addition, the OIG found that only 16 percent of beneficiaries received an educational service from their drug supplier, 8 percent made a non-billing inquiry to their drug supplier, 8 percent received an in-home visit, 5 percent had a care plan revision, and 3 percent received a respiratory assessment from their drug supplier at least once during 2003. Furthermore, the OIG report indicated that only 27 percent of beneficiaries had their medication compliance reviewed by drug supplier at least once in 2003, with 89 percent of these reviews occurring during refill calls. Accordingly, in light of the OIG findings regarding services actually provided, we remain unconvinced regarding the standard of care contentions set forth in comments concerning the 2004 and 2005 AAH reports.

As mentioned previously, we do not believe it is appropriate to include care management services such as patient education, caregiver training, care coordination, and in-home visits in the inhalation drug dispensing fee. Furthermore, the OIG found that few care management services were actually provided to a typical beneficiary. While it is possible that some types of care management services may be of potential benefit to some beneficiaries, at this time there is not clear evidence that such services are widely provided to beneficiaries nor have there been studies evaluating the effect of such services on beneficiary outcomes. Given such concerns, we do not believe it is appropriate for us to define dispensing fee under Medicare Part B to include care management services. However, we believe it is very important that the Medicare program support better patient care outcomes, particularly for beneficiaries with chronic respiratory conditions. We plan to explore how the Medicare program can engage physicians and their partners on issues of quality and performance to foster high quality of care for Medicare beneficiaries using respiratory drugs. For example, we believe there may be an opportunity under our demonstration authority to implement a demonstration program to test whether care management and care coordination services by physicians and their partners can improve health outcomes and reduce Medicare costs for beneficiaries who use inhalation drugs.

Comment: Some commenters criticized the OIG report as being too narrow in scope. A few commenters suggested that the OIG study excluded many essential services such as drug deliveries and billing activity that account for the bulk of services and costs. Another commenter suggested that the study did not capture all the services inhalation drug suppliers provide, including many that are required by State and Federal regulations (for example, Food and Drug Administration and State Pharmacy Boards), and standards of care for pharmacy practice. The commenters also criticized the OIG report for excluding billing services and not taking into account the substantial amounts of time spent doing the following: Collecting and processing the relevant billing information from the beneficiary and beneficiary's physician, which the commenter indicated often requires multiple on-site visits to doctors offices; verifying eligibility and processing reimbursement from secondary insurers responsible for payment of coinsurance; and researching and on-site verification of beneficiary financial and living circumstances in order to validate a waiver of coinsurance for hardship. The commenters also criticized the OIG report for not taking into account non-payment of coinsurance by Medicaid, the costs of Medicare billing requirements, and costs of oversight by multiple carriers. Furthermore, several commenters suggested that the OIG study undercounted services because the OIG survey instrument requested documentation for each service provided and the report focused on documented services. Some commenters suggested that this approach left out those services for which suppliers did not have documentation, either because they had discarded the documentation after it was no longer useful or because they had not documented services since there was no requirement to do so. Some commenters indicated that the mandatory refill calls require two telephone contacts on average before contact is made with the beneficiary. One commenter indicated that it maintains documentation of failed call attempts only for several months, and is not required to maintain long-term documentation of repeated calls and visits to patient homes and physicians' offices to gather documentation and information. In addition, one commenter noted that the OIG report expanded the categories of services it analyzed in its report based on information submitted by respondents in the survey instrument's ''other'' category. The commenter believed that this meant participants in the OIG report may not have always been explicitly asked about certain types of services. This commenter also criticized the OIG report for not conducting field work to observe the activities of inhalation drug suppliers, and indicated its belief that the GAO and 2004 AAH report included a more thorough analysis. Another commenter stated that the OIG report does not address the issue that the costs of dispensing drugs are higher than the current $57 fee for high quality suppliers in compliance with applicable requirements. Furthermore, the commenter stated that

[5] Office of the Inspector General, ''Review of Services Provided by Inhalation Drug Suppliers,'' September 2005, OEI–01–05–00090.

the service levels suggested in the OIG report are not representative of high quality suppliers. The commenter also stated that the behavior of noncompliant suppliers should not serve as a basis for reducing the fee because they contend the various services are required to comply with the regulations of Medicare, other government entities, and accrediting or quality assurance organizations.

Response: We do not find the criticisms of the OIG report persuasive. While a number of commenters criticized the methodology and findings of the OIG study, we believe that the results of the OIG study are credible. The OIG study examined the extent to which certain services such as patient/caregiver education, responding to patient/caregiver inquiries about drugs, revising the plan of care, contacting the physician's office, contacting a patient for a refill, reviewing medication compliance, and certain other services were actually being provided to beneficiaries by inhalation drug suppliers. The OIG failed to find evidence that many beneficiaries received such services from their inhalation drug suppliers, with the exception of drug refill calls.

Although some commenters criticized the OIG report for not including core dispensing activities such as filling the prescription and billing, the OIG report indicated that it did not focus on those activities because it did not have cause to question that they are necessary to dispense drugs and be reimbursed. The OIG instead focused on those services where less was known about the extent to which the services were actually being provided to beneficiaries. The OIG report examined a set of services that accounted for 60 percent of costs included in the 2004 AAH data. In addition, some costs cited by one commenter as being improperly excluded from the OIG study, such as non-payment of coinsurance by Medicaid, costs associated with waivers of coinsurance for indigent beneficiaries, and assessment of the beneficiary's situation for coinsurance waiver, are not generally reimbursed under Medicare Part B as a matter of general policy.

We are not persuaded by those commenters who suggested that the OIG study should be disregarded because the OIG undercounted the number of services suppliers actually provide due to the OIG's focus on documented services. Although the OIG focused its analysis on documented services, the OIG report indicated that if they had included undocumented services reported by suppliers in their analysis, the average number of services per beneficiary would still have been low (increasing from an average of 1.2 to 1.59 services per beneficiary per month). In addition, if various services are essential to dispensing these drugs to beneficiaries as some have suggested, we would have expected that suppliers would have documented the content and frequency of the services in patient records in order to track patient progress and maintain continuity of care. Furthermore, although some contend that the OIG study suggests that some suppliers are non-compliant in their provision of required services, as commenters pointed out, the OIG study did not generally collect information on the core services required to furnish inhalation drugs, with the exception of refill recalls. The OIG report found that not all beneficiaries who should have received a refill call actually got one. We plan to study the issue of refill call compliance further, and we believe it is important to reflect the costs of refills call in the dispensing fee.

In terms of the comment that the OIG study added several service categories based on information submitted by commenters, the survey instrument included an ''other'' category under which suppliers could report any services that were not captured by the categories provided. We do not view the opportunity for suppliers to elaborate on the types of services provided to be a weakness but rather a strength of the study. Although the OIG study was criticized by some for not conducting field work, the OIG adopted a methodology that was designed to provide information on a representative sample of beneficiaries receiving inhalation drugs.

While the OIG report does not provide information on supplier costs, that was not the objective of the OIG study. The OIG report provides information on the percent of beneficiaries that received various services from their drug suppliers, and as a result, and we believe it offers helpful information in our consideration of the inhalation drug dispensing fee.

Comment: We received a number of comments recommending either an increase or no reduction in the dispensing fee for 2006. Several commenters suggested the 2005 AAH report provided an appropriate fee for 2006. For that report, a consultant surveyed homecare pharmacies about what fee level they thought was appropriate for 2006. Survey respondents on average suggested a fee of $66.55 for a 30-day supply and a fee of $138.80 a 90-day supply. Suggested fees from other commenters ranged from $57 to $68, with a few commenters suggesting an inflation adjustment on top of those levels. One insurer commented that the current dispensing fee appears high.

Some commenters provided cost information as part of their contention that the fee should not be reduced or should be increased. One large supplier indicated that its costs were about $75 per beneficiary for a 30-day period, with the 3 cost categories accounting for the largest share being delivery, setup, and patient education ($20); clinical intake ($15); and compounding, dispensing, and assessment ($14). Another supplier indicated its costs broke out as follows: delivery, set-up, and patient education (27.3 percent); compounding, dispensing, pharmacy assessment (19.0 percent); patient intake (17.8 percent); follow-up and compliance monitoring (11.6 percent); quality assurance, accreditation, licensing and regulatory compliance (9.1 percent), other direct and indirect costs (4.2 percent). The supplier indicated that its costs were largely for salaries, freight and other delivery charges, and business infrastructure.

A number of commenters stated that the dispensing fee should not be based on retail pharmacy costs, stating that retail pharmacies do not provide the array of services that homecare pharmacies do. One retail pharmacy clarified its comments from the prior year cited in the proposed rule. By suggesting a fee of 5 to 6 times the current fee last year, the retail pharmacy said they meant 5 to 6 times the $10 proposed supplying fee (for immunosuppressive, oral anticancer, and oral anti-emetic drugs) for 2005 (that is, $50 to $60). In addition, a respiratory company stated that a comment received on the August 5, 2004 proposed rule from another retail pharmacy, which was cited in the August 8, 2005 proposed rule, may have been intended to mean $25 per prescription rather than $25 per 30-day period. Also, the commenter stated that the prior cost data was irrelevant because it preceded experience with the ASP system. Comments from retail pharmacies and a pharmacy association indicated support for the dispensing fee level urged by the 2005 AAH report.

A number of commenters stated there would be adverse effects on beneficiary access to inhalation drugs if the fee were reduced. Some suppliers asserted that they would reduce the services offered to beneficiaries or cease supplying inhalation drugs to Medicare beneficiaries. A number of commenters pointed to the 2005 AAH survey, which indicated that 45 percent of providers

would not accept Medicare patients if the dispensing fee were reduced more than a nominal amount, while 50 percent indicated they would reduce services provided to beneficiaries, and 2.5 percent indicated they would close. One commenter maintained that some providers had already closed or are seeking acquisition by other companies under current reimbursement rates. Another commenter speculated that a reduction in the dispensing fee would cause a shift away from small home care pharmacies to retail pharmacies, and asserted that these pharmacies would have to gear up by increasing inventories or directing patients to their mail order pharmacies. Some commenters suggested that a fee reduction could lead to adverse health effect for beneficiaries, reduced quality, or use of more intensive Medicare services. Others raised concerns that a reduction could create adverse incentives for substituting MDIs for nebulizers, even for patients where nebulizers are the preferred delivery mechanism.

Some commenters suggested that it is premature to reduce the dispensing fee. Some of these commenters asserted that CMS did not provide any new cost data in the proposed rule that would warrant a reduction. Several commenters stated costs had increased due to higher fuel prices, unforeseen natural disasters, and wage inflation. Several commenters pointed to the 2005 AAH study which indicated that the average cost of shipping increased from $12.13 in 2004 to $14.41 in 2005. One commenter indicated that its overnight shipping costs were between $27 to $40 per shipment. Another commenter cited a 12.5 percent increase in the fuel surcharge cap for one large shipping company, which they indicated would cause their delivery costs to increase an additional 4 percent on top of prior increases. One commenter indicated that its cost per shipment had increased by $0.40 due to increased fuel costs in 2005, and it expected additional future increases. In urging an increase in the fee to take into account inflation, another commenter mentioned that it had consolidated the number of pharmacies it operated to increase efficiency, but indicated that the number of costs that could be reduced was limited. Another commenter stated that we should not reduce the fee because the agency indicated in a October 8, 2004 letter to GAO that a fee of $55 to $64 was a reasonable range for a 2005 fee. Other commenters asserted that experience with the ASP system and the current dispensing fee is too limited to conclude there are overpayments. One commenter stated that the payment reduction in 2005 was greater than the Congressional Budget Office or the CMS Actuaries Office had projected prior to passage of the Medicare Modernization Act. This commenter suggested actual levels in 2005 claims data be compared to original estimates before taking any action.

Response: As noted previously, we established the 2005 dispensing fee using data from the 2004 AAH report. That report included costs for a wide range of services beyond basic dispensing, such as patient education, caregiver training, care coordination, and in-home visits. As discussed previously, we believe these activities represent care management services that should not fall within the scope of a dispensing fee. Furthermore, the September 2005 OIG report found little evidence that many beneficiaries receive these care management services. Consequently, we are establishing a dispensing fee for 2006 using the 2004 AAH cost data excluding separable costs for care management services. We believe this interpretation represents an appropriate reading of the statute. Based on the 2004 AAH data for homecare pharmacies, excluding costs for care coordination, in-home visits, patient education, and caregiver training (as well as sales, marketing, bad debt and profit which were also excluded last year because Medicare does not generally reimburse those costs with respect to Part B services), we are establishing a dispensing fee of $33 for a 30-day supply of inhalation drugs. Because greater levels of effort may be involved in dispensing inhalation drugs when a patient begins these drugs for the first time, we have decided to maintain the current $57 dispensing fee for the first 30-day period in which an individual uses inhalation drugs as a Medicare beneficiary. Thus, beginning in 2006, we will pay a dispensing fee of $57 for the first month an individual uses inhalation drugs as a Medicare beneficiary, and $33 for a 30-day supply of inhalation drugs for all other months.

Although some commenters urged an inflation adjustment, we do not believe it is warranted for 2006 because we do not believe it is clear that total dispensing costs have increased since the 2004 industry cost data was collected. Although data from the 2004 industry report may not reflect wage inflation or increased delivery costs due to fuel price increases, it would also not include any efficiencies that providers may have achieved as they have adjusted to the new payment system in 2005. The 2005 AAH report did not provide updated cost data for the service categories included in the 2004 AAH report. Given that the 2004 AAH cost data would not reflect inflationary pressures, nor increased efficiencies in business operations, it is uncertain whether an upward or downward adjustment to the 2004 cost data should be made. As a result, we believe it is best to use the 2004 AAH data as is. We will consider the appropriateness of an inflation adjustment for the future.

Regarding concerns raised by some commenters about beneficiary access, we believe, as discussed previously, that the fee level we are establishing is appropriate to cover suppliers' dispensing costs, and beneficiaries will maintain good access to inhalation drugs. The fee amount is based on the 2004 AAH cost data for clinical intake, establishing/revising the plan of care, delivery of services, refill calls/compliance monitoring, billing/collections, ''other'' direct costs, and indirect costs, excluding sales, marketing, bad debt, and profit which are not reimbursed by Medicare. Having based the 2006 dispensing fee on industry cost data for those activities that we believe fall within the scope of a dispensing fee, we believe the fees are appropriate to cover providers' costs and will not impair access. In addition, we will continue to monitor access to care.

Regarding concerns raised by some commenters about CMS lowering the fee without the benefit of new cost data, we believe it is our fiduciary responsibility to establish an appropriate payment for 2006. As discussed previously, our decision is based on our determination that certain services should not fall within the scope of the dispensing fee and the OIG report which found that these services are furnished infrequently to beneficiaries. We believe our decision to lower the fee for 2006 is consistent with our October 8, 2004 letter to the GAO, in which we stated that a dispensing fee in the range of $55 to $64 would be appropriate for the interim 2005 fee. Regarding the comment that the savings from the ASP system are greater for inhalation drugs than the savings projected by CBO or the CMS actuaries prior to enactment of the MMA, we recognize the concerns regarding the shift from a payment system based on AWP; however, we do not believe such concerns are an appropriate consideration in determining the dispensing fee for 2006. Medicare does not generally establish payment rates based on budget projections. Rather, we use the most reliable cost data available to establish

a payment rate that is consistent with the statute and appropriate for Medicare covered services.

Comment: In response to our request for comments on providers' experience with the dispensing fee for a 90-day supply, we received a number of comments. One commenter pointed to the 2005 AAH survey, which found that most respondents (77 percent) do not provide a 90-day supply, and among those that do it represents 3 percent of their business. Reasons cited by survey respondents for non-use of a 90-day supply included—(1) 30-day supply promotes more contact with patients and compliance monitoring; (2) patient prescriptions often change; and (3) many suppliers believed the 90-day dispensing fee ($80 in 2005) was not adequate to cover costs. Less than 1 percent indicated they do not provide a 90-day supply because it is less profitable than a 30-day supply. A few other commenters raised concerns about the 90-day dispensing fee and provided similar reasons for non-use of the 90-day supply as the 2005 AAH survey. In addition, one commenter cited Medicare's refund requirements for unused drugs as being another reason for non-use of the 90-day supply. However, one commenter suggested that the 90-day supply is not used because it receives less reimbursement overall than using the 30-day supply. A physician specialty group supported the 90-day prescription because it reduces paperwork and redundant efforts by patients, physicians, and DME suppliers.

Response: We agree with the physician specialty group that dispensing a 90-day supply has merit; thus, we have continued the 90-day dispensing fee for 2006. As cited by respondents to the 2005 AAH study, a 30-day supply may be most appropriate for certain beneficiaries such as those with changing prescriptions. However, for those situations where it is medically appropriate, we believe it is important to have a 90-day option available.

In the CY 2005 final rule, we calculated the 90-day dispensing fee by taking direct costs for the 30-day fee and tripling indirect costs (which was based on the methodology used in the October 2004 GAO report). However, as discussed, some commenters voiced concern about the adequacy of the 2005 90-day dispensing fee. Some commenters supported the reimbursement amounts suggested by respondents in the 2005 AAH survey. In that survey, respondents suggested an average fee for a 90-day supply ($138.80) that was roughly twice the amount they suggested for a 30-day supply ($66.55). For 2006 using a 2 to 1 ratio for the 90-day versus 30-day fee would yield a 90-day fee about 40 percent higher than our previous methodology. We believe it is important that adequate reimbursement be available for the 90-day option, as well as, the 30-day option. Therefore, using the 2 to 1 ratio recommended by commenters for the 90-day versus 30-day supply payment rates, we are establishing a fee of $66 for a 90-day supply of inhalation drugs for 2006.

Although we established two levels of dispensing fees for a 30-day supply, an initial 30-day fee of $57 and a 30-day fee of $33 for all other months, we do not believe a higher initial fee is warranted for a 90-day supply given that we do not believe a 90-day supply is generally used when a beneficiary first begins inhalation drugs. A number of commenters noted that the 90-day supply is not well-suited for patients whose prescriptions are likely to change. We recognize that beneficiaries who begin using inhalation drugs for the first time are more likely than established patients to experience changes in drugs or dosages, or to discontinue use altogether. Accordingly, we do not believe it is appropriate to encourage use of a 90-day supply when a beneficiary first begins using inhalation drugs by establishing a higher initial 90-day fee. Consequently, given such concerns, we have not provided two levels of dispensing fees with the 90-day option.

Comment: Some commenters noted that refill calls are a service required by Medicare.

Response: We agree that Medicare requires that a supplier confirm that a beneficiary needs a refill before sending a new shipment, and we have included the costs of refill calls from the 2004 AAH report within the dispensing fee.

Comment: A few commenters suggested that many of the activities they carry out are required to maintain compliance with FDA, Medicare, and State regulations, and with standards imposed by accrediting bodies such as JCAHO. Some commenters noted that CMS has issued draft supplier quality standards, and that they are required to provide certain services as part of those standards. The commenters suggested that the dispensing fee should accommodate their costs in these areas.

Response: With the exception of certain guidelines concerning compounding, we do not believe that the requirements applicable to inhalation drug suppliers are in general substantially different from the requirements applicable to pharmacies dispensing other drugs. Furthermore, we view costs such as regulatory compliance and quality assurance as part of overhead, which we have included in the dispensing fee based on the 2004 AAH cost data for overhead and other direct costs. We also do not believe that the costs associated with regulatory requirements applicable to equipment suppliers should be compensated through the inhalation drug dispensing fee. The Medicare program makes separate payments to equipment suppliers for rental/purchase of nebulizers and maintenance, and regulatory requirements applicable to equipment suppliers would be covered through the basic payment rates for the equipment, not the Medicare payment rate for drugs or dispensing.

Regarding the draft supplier quality standards that have been released for comment, we note that the agency has adopted a two-step process for developing those standards. An initial document with draft quality standards for suppliers of several types of durable medical equipment has been released for public comment. We expect to release a second document that will clarify which quality standards apply to inhalation drug suppliers. We expect that the standards applying to inhalation drug suppliers will be consistent with accepted quality standards for pharmacies. Furthermore, the standards will establish minimum requirements for being a supplier, which we consider to be part of the standard cost of doing business that is covered through our basic payment rates. As with conditions of participations (COP) for providers, we do not increase our payment rate as a result of a change in COP requirements.

Comment: One commenter stated that section 1842(b)(3) of the Act requires Medicare payments be reasonable. The commenter asserted that the agency has established in § 405.502(a) criteria for determining what is reasonable, and stated that Medicare has a history of recognizing and reimbursing services related to patient care.

Response: We recognize the commenter's concern regarding the reasonableness of Medicare payments. We have based the dispensing fee payment rates on industry cost data from the 2004 AAH report, which was submitted as part of comments by AAH on the CY 2005 proposed rule, and used in the CY 2005 final rule, to establish the 2005 dispensing fee. To establish the 2006 dispensing fee, we have used the 2004 AAH cost data excluding those services that fall outside the scope of a dispensing fee.

Comment: Some commenters cited Medicare's drug payment rates (ASP+6 percent) as a reason the dispensing fee should remain the same or be increased. One homecare pharmacy indicated that it could not obtain drugs at ASP+6 percent. A few commenters stated that their costs exceed reimbursement for drugs in cases where a physician writes brand medically necessary and the drug is in a billing code that contains both brand and generic drugs. An inhalation drug supplier indicated that for three inhalation drugs its acquisition costs exceeded Medicare reimbursement. Some commenters indicated Medicare drug payments (ASP+6 percent) were inadequate for a variety of reasons such as exclusion of wholesaler markup from ASP, the lag time between sales for a quarter and the inclusion of such information in the Medicare ASP+6 drug payment rates, volatility in ASP+6 reimbursement from quarter to quarter, and class of trade differences in pricing. One commenter suggested that Medicare had addressed concerns about the adequacy of ASP+6 percent reimbursement for oncology patients by implementing the Demonstration of Improved Quality of Care for Cancer Patients Undergoing Chemotherapy. They also suggested that the ASP+6 percent cap on reimbursement for the upcoming Part B drug competitive acquisition program (CAP) was a reason for its delay, because they asserted vendors did not want to commit to a program where ASP+6 percent was the reimbursement limit. The commenter stated that the issues it has encountered with ASP+6 percent are similar to the issues faced by oncologists and vendors under CAP program and therefore should be addressed through the inhalation drug dispensing fee.

In addition, a few commenters suggested that Medicare payments for equipment were inadequate, necessitating a substantial dispensing fee.

Response: Although some commenters stated that the dispensing fee should account for drug acquisition costs in excess of the ASP+6 percent payment, we disagree. Section 1847A of the Act specifies that the Medicare payment for inhalation drugs is at 106 percent of the ASP. We believe the Congress established the ASP based payment for inhalation drugs and separate authority for dispensing of these drugs for good reason, namely to pay appropriately for each service and to eliminate cross subsidization of services. Similarly, we believe payment for nebulizer equipment is a distinct policy separate from the dispensing fee, and one should not cross subsidize the other. In establishing the dispensing fee of $33 for a 30-day supply of inhalation drugs (and higher first month payment), we are focusing on what we believe is the appropriate scope and payment for the dispensing fee.

Although one commenter suggested that we had addressed perceived issues about ASP+6 percent payment adequacy by implementing the Demonstration of Improved Quality of Care for Cancer Patients Undergoing Chemotherapy, we disagree. The purpose of the demonstration program is to promote improvements in quality by measuring patient outcomes in several areas of concern often cited by patients undergoing chemotherapy, which can then be traced to treatments and outcomes. In addition, we believe that the commenter's statement that the change in the timeframe for implementation of the Medicare Part B drug CAP was a result of the ASP+6 percent cap on vendor reimbursement is not accurate and not related to the inhalation drug dispensing fee.

Comment: A few commenters expressed concern that the 30-day dispensing fee is the same regardless of the number of prescriptions dispensed. They noted that if a prescription is changed in the middle of the 30-day period they do not receive an additional fee. They suggested CMS consider a per script fee.

Response: The dispensing fee amount we have established is based on the 2004 AAH report data, which presented average costs for a month. Consequently, we believe our payment rate should be adequate to cover situations where multiple prescriptions are provided. We will consider the suggestion of a per script fee in future rulemaking, as necessary.

Comment: Several commenters indicated that our revised guidelines concerning the timeframe for shipping refills had not reduced their need to use of overnight shipping. An industry association indicated that several factors often force overnight shipping such as hospitals giving beneficiaries only a one or two dose supply and beneficiaries waiting until they are out of medication to reorder. The 2005 AAH survey indicated that the percent of shipments that were overnight increased slightly from 56.3 percent in 2004 to 56.9 percent in 2005. One commenter indicated that 60 percent of its shipments occur on an overnight basis because of several factors such as needing multiple calls to reach a beneficiary and new prescriptions reportedly needing to be shipped overnight. The commenter urged us to permit refill calls as needed to be ready to ship refill orders at least 7 days before the patient's medication runs out. The commenter believes that this would allow for ground shipping in most cases, including refill dates that fall on weekends and 3-day holidays. One commenter suggested that the 30-day dispensing fee reimbursement guideline had reduced the amount of drugs that they could ship in a month, necessitating more use of overnight shipping. In addition, one commenter asserted if beneficiaries come in for a refill before the end of the month, then the pharmacy would receive no fee. While most commenters indicated that the revised delivery timeframes had not had a substantial impact on their delivery practices, one commenter indicated that 70 percent of its shipment through the third quarter of 2005 were ground deliveries, and they hoped to transition an additional 20 percent of shipments to ground delivery in the fourth quarter of 2005 as a result of Medicare's extension of the patient notification and shipment window.

Response: In the CY 2005 final rule, we made several administrative changes aimed at reducing inhalation drug supplier costs, including providing more flexible refill timeframes. We currently allow refills to be sent up to approximately 5 days before the end of the current usage period. To further facilitate the use of ground delivery, we are in the process of working to expand this timeframe to allow refills to be sent up to 7 days before the end of the current usage period. Under this new delivery timeframe, we will allow a dispensing fee to be paid up to 7 days before the end of current usage period, with up to 12 months of dispensing fees payable per year per beneficiary.

In addition, we note that for 2006, we are establishing a dispensing fee of $57 for the first month an individual uses inhalation drugs as a Medicare beneficiary because greater levels of effort may be involved in dispensing inhalation drugs when a patient begins these drugs for the first time, for example, following hospital discharge.

Comment: Many commenters responded to our request for comments on the impact of Medicare Part D coverage of metered dose inhalers on beneficiary access to care. A number of commenters asserted that they did not believe there would be a substantial shift to MDIs when they become covered under Medicare Part D. One commenter said that MDIs are not a substitute for nebulizers, as many patients require nebulizers due to inability to use MDIs properly, or physicians' experience has shown nebulizers are more effective than MDIs.

Another commenter said that although research has not been able to demonstrate the superiority of nebulizers to MDIs, nebulizers are the standard of care for COPD and chronic lung diseases in the moderate to severe stages. Other reasons commenters cited for their belief that there would not be a substantial shift to MDIs include: Physician inability to properly train patients on MDIs; patient familiarity with nebulizer use gained during hospital stays; research suggesting patient preference for nebulizers; potential use of nebulizers and MDIs by the same patient; and potential differences in cost-sharing across Medicare Part B and Part D. However, one physician specialty group said that it anticipates many Medicare beneficiaries will migrate to MDIs, and those that remain on nebulizers will be more frail and in need of more personalized service.

Response: We believe expansion of Medicare coverage of inhalation drugs to include MDIs under Medicare Part D will provide additional options for treatment and positively impact access to care. As we indicated in the proposed rule, we recognize that nebulizers are required by many beneficiaries because of their individual circumstances. We believe that physicians will choose the treatment option that best meets a beneficiary's needs, and both nebulizers and MDIs will play an important role in the Medicare program in the years to come.

Comment: A health professional association asserted that individuals that provide patient education on use of nebulizers, MDIs, and dry powder inhalers (DPIs) should be qualified by virtue of education, training, and competency testing. It also urged CMS to pay a separate education fee to physicians when prescribing an MDI or dry powder inhaler. The commenter also proposed various levels of fees for initial and follow-up services.

Another commenter raised concerns about what it asserts is a trend toward drop shipping respiratory related devices. The commenter expressed concern that contact between a respiratory patient and provider may disappear, raising potential concerns about correct usage of the respiratory device.

Response: We agree that it is important that beneficiaries are properly trained in the use of nebulizers. The Medicare program provides that equipment suppliers either directly train the beneficiary in the use of the nebulizer or ensure that the beneficiary has been trained by other qualified individuals (§ 424.57(c)(12)). In addition, under the physician fee schedule, Medicare will pay physicians to train the beneficiary in the use of a nebulizer, MDI, or inhalation device (CPT code 94664, demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device).

Comment: One commenter stated that CMS evaded its notice and comment rulemaking obligations under the Administrative Procedures Act (APA) to collect meaningful data in support of an appropriate dispensing fee. The commenter urged us to publish data in a subsequent rule, and seek comment, before publishing a final payment rate for 2006.

Response: In the August 8, 2005 proposed rule, we identified and reviewed available studies and data on the cost of providing inhalation drugs, sought comment as well as additional data and information concerning an appropriate payment amount and scope, and indicated that we thought it likely that the payment amount for 2006 would be lower than the current amount. Furthermore, in establishing the 2006 dispensing fee, we analyzed the available studies and data in response to comments received on the proposed rule and based on that analysis have continued to use the 2004 AAH data that was identified in the proposed rule and also used to establish the 2005 fee. Furthermore, as discussed previously, it is our opinion that the rates established in this rule are appropriate in light of the statute and our understanding of Congressional intent. We believe, therefore, this met our obligations under the APA.

Comment: One commenter took issue with our description in the proposed rule of inhalation drugs as supplies.

Response: Medicare coverage of inhalation drugs is derived from their use in covered nebulizers. For Medicare coverage purposes, they are considered covered supplies.

Comment: A few commenters expressed concern about precedents Medicare Part B will set for Medicare Part D. They asserted that 90-day scripts are not appropriate for nursing home patients.

Response: The Medicare Part B policy concerning a 90-day dispensing fee does not carry over to Medicare Part D.

Comment: Although the assignment of benefits form (AOB) has been eliminated, one commenter noted that the requirement to obtain a payment authorization signed by the beneficiary before submitting the claim diminishes the benefit of eliminating the AOB. The commenter urged CMS to eliminate the requirement for signed payment authorization for providers and those reimbursed based on assignment only.

Response: We thank the commenter for the comment. CMS is reviewing the beneficiary signature requirement for claims submission in light of the elimination of the AOB form in instances of mandatory assignment. However, CMS currently requires a beneficiary signature for claims submission.

Comment: One drug manufacturer suggested that compounding that attempts to mimic production of commercially available products threatens patient safety. The commenter urged CMS to structure the dispensing fee to reduce the likelihood of inappropriate compounding. The commenter also suggested code modifiers for pharmacy-compounded medications to help identify their occurrence. Another drug manufacturer suggested that reducing the dispensing fee could spur suppliers to provide compounded versions of commercially available products without physician or patient authorization. The commenter suggested that we review supplier documentation to ensure compounded solutions are only furnished where documentation supports medical necessity of a customized product.

Response: The inclusion of costs for pharmacy compounding in the dispensing fee is not in any way an endorsement of compounding that is inconsistent with FDA guidelines. Furthermore, Medicare expects that pharmacies comply with FDA guidelines irrespective of the dispensing fee payment amount established. We understand the concerns the commenters raised and will consider the issues further.

Comment: One commenter urged us to require code modifiers for claims associated with patient compounding of inhalation drugs. The commenter asserts that when a physician writes a prescription for a compounded drug, the inhalation drug supplier has an incentive to dispense the drugs separately in order to obtain two dispensing fees. The commenter asserts that implementing the modifiers would allow us to pay only one dispensing fee, instead of two, under these circumstances.

Response: Medicare pays only one dispensing fee per 30-day (or 90-day) period, regardless of the number of drugs dispensed. As a result, these modifiers would not affect Medicare expenditures.

Comment: We received some comments in response to our request for information about why there is substantial variation in costs across

suppliers. A few commenters suggested that many beneficiaries receive services from small providers who may have higher costs.

Response: We appreciate the comments. We note that the GAO report, which showed wide cost variation, found that larger suppliers did not necessarily have lower costs than small suppliers. We continue to believe that this is an issue that might benefit from further study.

5. Supplying Fee

Section 303(e)(2) of the MMA added section 1842(o)(6) of the Act which requires the Secretary to pay a supplying fee (less applicable deductible and coinsurance) to pharmacies for certain Medicare Part B drugs and biologicals, as determined appropriate by the Secretary. The types of Medicare Part B drugs and biologicals eligible for a supplying fee are immunosuppressive drugs described in section 1861(s)(2)(J) of the Act, oral anticancer chemotherapeutic drugs described in section 1861(s)(2)(Q) of the Act, and oral anti-emetic drugs used as part of an anticancer chemotherapeutic regimen described in section 1861(s)(2)(T) of the Act.

Beginning with CY 2005, Medicare established a supplying fee of $24 per prescription for these categories of drugs, with a higher fee of $50 for the initial oral immunosuppressive prescription supplied in the first month after a transplant. When multiple drugs are supplied to a beneficiary, a separate supplying fee is paid for each prescription, except when different strengths of the same drug are supplied on a single day. When we established the $24 supplying fee in the CY 2005 final rule (69 FR 66236), we indicated that we were establishing a rate higher than that of other payers due to the additional costs associated with Medicare Part B's lack of online claims adjudication.

As part of the August 8, 2005 proposed rule (70 FR 45848), we proposed changes to the supplying fee for multiple prescriptions supplied during the same month. We proposed to continue paying $24 for the first prescription supplied during a month (or $50 for the first oral immunosuppressive prescription supplied in the first month after a transplant) and a supplying fee of $8 for each additional prescription the pharmacy supplied to the beneficiary during the same month. Each pharmacy supplying these drugs to a beneficiary during a month would be entitled to one $24 supplying fee per beneficiary during that month. In making this proposal, we indicated that when a pharmacy supplies multiple drugs to a beneficiary during the same month, many of which are likely to be supplied on the same day, we were concerned that we were overpaying for the costs associated with our lack of online claims adjudication. Furthermore, we indicated that we believe that the $24 supplying fee for the first prescription would adequately compensate a supplier for the billing costs associated with the lack of on-line claims adjudication, and that the cost of supplying additional prescriptions in the same month should be comparable to that of other payers.

We also proposed to expand the circumstances under which we pay supplying fees for multiple prescriptions filled on the same day. Currently, we pay a supplying fee for each prescription supplied on the same day as long as the prescriptions are for different drugs. We proposed to pay a supplying fee for each prescription, even if the prescriptions are for different strengths of the same drug.

We requested comments about the appropriateness of our proposed supplying fee for multiple prescriptions supplied during a single month along with data and information about the incremental costs of supplying additional prescriptions to a Medicare beneficiary during a single month. We also asked for comments about how pharmacy costs and reimbursement for supplying oral drugs under Medicare compares to that of other payers.

We received numerous comments regarding our supplying fee proposals. Those comments and responses are provided below.

Comment: Numerous commenters were supportive of our proposal to expand the circumstances under which we pay a supplying fee to include paying separate fees when multiple strengths of the same drug are supplied on the same day. However, many commenters expressed concern about our proposal to pay a supplying fee of $24 to a pharmacy for the first prescription and $8 for all subsequent prescriptions supplied in a 30-day period. Commenters generally urged no reduction in the supplying fee when multiple prescriptions are provided in the same month, and a few urged a payment increase. In opposing the $8 subsequent fee, some commenters stated that the agency had included no new cost data in the proposed rule to support a reduction. At the same time, some commenters provided cost information as part of their comments.

A few commenters indicated that the cost of supplying a drug for an insurer with online claims adjudication had increased from $8 (as cited in the proposed rule) to $9 to $10 based on new studies. An association representing chain drug stores provided information from a few large chains indicating that the average cost to supply a Medicare Part B prescription was between $19 and $21, noting that small chains or independent pharmacies may have higher costs. The association asserted that the current $24 fee was reasonable considering the fact that Medicare currently does not pay separate supplying fees for different strengths of the same drug supplied on the same day. The association urged us to consider an increase in the $24 fee to take into account inflation, and an increase in the $50 fee for the first prescription after a transplant to compensate for the intense patient monitoring that the association indicated was needed. A large chain pharmacy indicated its average cost of supplying a Medicare prescription was $19.02, which included $5.54 for bad debt.

An association for specialty transplant pharmacies submitted data suggesting that Medicare's reimbursement (combined payment for the drug and supplying fee) to these pharmacies for 2 large volume immunosuppressive drugs is comparable or lower than that of Medicaid or private payers. This association pointed to a 2004 report prepared by a consultant, which indicated that specialty pharmacy costs for immunosuppressive drugs for Medicare patients averaged about $35. This association also indicated that transplant pharmacies have higher costs because they offer more extensive services, routinely stock specialty medicines and maintain regular and consistent contact with their Medicare clients. The association suggested that these services should be compensated through the supplying fee. In addition, this association also claimed that chain pharmacy data collected in a similar manner to the specialty pharmacy data yield costs of $21. The group asserted that the chain costs appear lower than the specialty pharmacy costs in part because chains supply items such as diabetic test-strips, which they indicate cost less to supply.

In opposing a reduction in the supplying fee for subsequent prescriptions in a month, a number of commenters took issue with the rationale provided in the proposed rule for the reduction, saying that there are not economies of scale in processing Medicare claims when multiple prescriptions are provided in the same month. Many commenters outlined costs associated with billing Medicare.

Because of the lack of online claims adjudication, some stated that there was more bad debt associated with Medicare Part B claims. Other commenters indicated that it takes longer to process a Medicare claim because of the requirement of a signed order from the physician as well as the lack of online claims adjudication. Some commenters indicated that without online claims adjudication, pharmacies must call the DMERC to check the beneficiary's deductible as well as verify whether the beneficiary is still enrolled in traditional Medicare as opposed to Medicare Advantage. Other commenters indicated that the lack of online claims adjudication and automatic cross over claims means that they may have to refund a beneficiary's coinsurance if it is later determined that the beneficiary has supplemental insurance. Other billing activities and requirements that commenters cited as creating added costs include: contracting with a special entity to convert Medicare Part B claims from the NCPDP format to ANSI X837; working with physicians to determine whether oral anticancer or anti-emetic drugs are being prescribed for Medicare Part B covered indications; having to submit the unique physician identifying number (UPIN) on the claim; and Medicare's requirement that the date of service and date of prescription be the same.

Although most commenters did not support the proposal for a reduced fee when multiple prescriptions are supplied in a month, one health insurer commented that the current supplying fee payment amounts appear high, and put upward pressure on commercial rates.

Response: As we indicated in the CY 2005 final rule (69 FR 66236), we recognize that the cost of supplying Medicare Part B drugs is somewhat higher than that of other payers because of the lack of on-line claims adjudication for Medicare Part B claims. We believe it is appropriate for Medicare's supplying fee to compensate for the Medicare billing costs associated with the lack of online claims adjudication. However, as we indicated last year, we do not believe the supplying fee for these drugs should be higher than other payers for reasons other than the lack of on-line claims adjudication.

The comments included information on the costs of supplying Medicare Part B drugs for some chain pharmacies. One chain reported Medicare costs of $14.48 ($19.02 – $5.54 non-reimbursed bad debt). A retail pharmacy association commented that a few chains had indicated that their costs of supplying a Medicare Part B prescription were between $19–$21 per prescription (without indicating whether bad debt was included). Furthermore, as we indicated in the August 14, 2004 final rule (69 FR 66236), our analysis of data from a 2004 survey of specialty pharmacies yields a supplying fee in the range of $13–$27 depending on the proportion of personnel costs assumed to be associated with Medicare billing. This range was developed by using a figure of $5 or $10 for the payment rates of payers with on-line adjudication, and adding to that Medicare claims processing costs from the specialty pharmacy data ($8), and a portion of personnel costs from the specialty pharmacy data (total was $9) assumed to be related to Medicare billing. This results in supplying fee between $13 ($5 + $8) and $27 ($10 + $8 + $9), depending on the portion of personnel costs associated with Medicare billings.

Based on this information from chains and specialty pharmacies, we agree that an $8 fee for subsequent prescriptions is too low. However, as discussed in more detail subsequently, our analysis of the cost information from the comments has led us to believe that a subsequent prescription supplying fee that is slightly lower than $24 would be appropriate. Based on our analysis, we believe that a $24 fee for the first prescription in a 30-day period, and a $16 fee per prescription for all subsequent prescriptions in the 30-day period would be consistent with the cost information included in the comments. Under this fee structure, reimbursement to a pharmacy for the supplying fee would average $24 for a patient with 1 prescription in a 30-day period, $20 per prescription for patients with 2 prescriptions, $18.67 per prescription for a patient with 3 prescriptions, and $18 per prescription for a patient with 4 prescriptions, for example. Our claims data currently indicate that beneficiaries receiving immunosuppressive, oral anticancer, or oral anti-emetic drugs under Medicare Part B average 2.2 prescriptions per month, with a majority receiving 4 or fewer. We believe average supplying fee payments ranging from $18 to $24 are consistent with the chain drug store costs indicated in the comments and falls within the mid-range of the potential supply fee amounts we calculated based on the specialty pharmacy data survey.

Because we continue to believe that there are some economies of scale for Medicare billing costs when multiple prescriptions are supplied in the same month, particularly when they are billed on the same claim form, we believe it is appropriate to pay a higher fee for the first prescription in a 30-day period, and the somewhat lower fee for all subsequent prescriptions in the 30-day period. For example, several activities related to Medicare billing that commenters cited as being costly including calling the DMERC to verify the beneficiary's Medicare fee for service eligibility, locating the physician's UPIN to include on the Medicare Part B claim form, handling coinsurance refunds for crossover claims, and completing other information on the claim form would only have to be performed once, rather than twice, when multiple prescriptions are submitted on the same claim. Moreover, following through on our proposal to expand payment of the supplying fee to include paying separate fees when multiple strengths of the same drug are supplied on the same day, we believe it is important that the subsequent prescription supplying fee reflect lower incremental costs.

Consequently, beginning in 2006, we are establishing a supplying fee of $24 for the first prescription in a 30-day period, and $16 for each subsequent prescription in the period. Each pharmacy will be eligible for one $24 fee per beneficiary per 30-day period. As mentioned previously, beginning in 2006 we are also expanding the circumstances under which we pay the supplying fee to include paying separate fees for different strengths of the same drug that are a supplied on the same day. We are not altering the current policy of paying a $50 supplying fee for the first immunosuppressive prescription after a transplant. If a supplier receives a $50 supplying fee for the initial prescription after a transplant, a supplying fee of $16 will be paid for all subsequent prescriptions, after the initial prescription, furnished by that supplier to the beneficiary during that 30-day period.

We are making conforming changes to § 414.1001(b) to reflect this policy concerning subsequent prescriptions supplied during the same 30-day period as the initial immunosuppressive prescription after a transplant.

Comment: A number of commenters expressed concerns about beneficiary access if the supplying fee were reduced. Some suggested that pharmacies may stop providing these drugs to beneficiaries if the supplying fee is lowered. Others believe that a reduction in the fee could lead specialty pharmacies to stop providing support services to transplant patients, which they assert could adversely impact transplant success for some patients.

Response: We believe the supplying fee payment amounts we have established are appropriate based on the cost information available from the comments, and beneficiaries will continue to have good access to these drugs. Furthermore, we note that the reduction in Medicare payments resulting from the supplying fee changes are expected to represent at most 1 percent of Medicare total payments to pharmacies for these drugs.

Comment: Some commenters expressed concern about the reduction in reimbursement that would result from the subsequent prescription supplying fee in certain situations (for example, for drugs that have a 3-week prescription cycle or for patients with 3 prescriptions per month).

Response: Under the supplying fee rates established for 2006, Medicare reimbursement for the supplying fee would in the majority of cases average from $24 (patient with 1 Medicare Part B prescription) to $18 (patient with 4 Medicare Part B prescriptions). As mentioned previously, we believe this range of average reimbursement is consistent with the chain pharmacy cost information in the comments and falls near the mid-range of the potential supplying fee payment amounts we calculated based on the 2004 survey data for specialty pharmacies. Furthermore, we believe the supplying fee payment rates appropriately reflect the potential for economies of scale when multiple prescriptions are supplied in the same month.

Comment: A few commenters stated that a lower subsequent prescription fee may encourage pharmacies to send patients to affiliate locations in order to receive the $24 fee.

Response: We disagree. As mentioned previously, we believe that the supplying fee payment rates established are adequate to cover pharmacies' supplying costs based on the cost information included in the comments. We do not believe that these reimbursement changes would spur pharmacies to take actions that would cause inconvenience to the beneficiaries they serve.

Comment: Some commenters maintained Medicare's drug payment rates (the average sales price + 6 percent) were below their acquisition costs for certain drugs, and stated that the current $24 per prescription supplying fee should be unchanged or increased to compensate for this.

Response: Although some commenters stated that the supplying fee should account for drug acquisition costs in excess of the ASP+6 percent payment, we disagree. Section 1847A of the Act specifies that the Medicare payment for these drugs is at 106 percent of the ASP. We believe the Congress established the ASP based payment for these drugs and separate payment for the supplying of these drugs for good reason, namely to pay appropriately for each distinct service. In expanding the circumstances under which we pay a supplying fee and establishing the supplying fee payment amounts ($24 for the first prescription in a 30-day period and $16 for all subsequent prescriptions in a 30-day period, as well as the $50 fee for first immunosuppressive prescription after a transplant), we are focusing on the appropriate scope and payment for the supplying fee.

Comment: A few commenters suggested that for 2006 the current supplying fee payment amounts ($50 for initial prescription after a transplant, and $24 per prescription otherwise) be increased for inflation or to ensure adequate reimbursement for services provided by suppliers.

Response: We believe that the supplying fee payment amounts we have established for 2006 are consistent with the cost information from the comments this year. We will consider an inflation adjustment for the future.

Comment: Some commenters raised concern that if a beneficiary sought a refill before the end of the month, the pharmacy would not be eligible for a $24 fee for that refill.

Response: We understand the commenters' concern. We are taking several steps to address this potential issue. First, we have decided to use a 30-day period rather than a calendar month as the basis for determining whether a $24 or $16 supplying fee is payable. Thus, we will pay a $24 supplying fee for the first prescription supplied by a pharmacy in a 30-day period (or a $50 supplying fee for the first immunosuppressive prescription after a transplant), and a $16 supplying fee for each subsequent prescription supplied by that pharmacy to the beneficiary in the 30-day period. We believe using a 30-day period avoids arbitrary fluctuations in payment that might otherwise occur as a result of variation in the number of days per month. In addition, in our instructions to implement the 2006 supplying fee, we will allow a $24 supplying fee to be paid for a refill prescription up to 7 days before the end of the 30-day period for which the last $24 supplying fee was paid to that pharmacy, with up to twelve $24 supplying fees payable per beneficiary per year.

Comment: A number of commenters expressed concern that the assignment of benefits (AOB) forms, which the August 14, 2004 final rule indicated would be eliminated, has not yet been eliminated.

Response: The requirement that a pharmacy obtain an AOB form when supplying drugs to a beneficiary was eliminated for dates of services on or after January 1, 2005. Because of technical issues, the claims processing contractors did not immediately implement this change. We published a change request in August 2005 clarifying that the requirement for an AOB form was eliminated effective January 1, 2005 for pharmacies supplying Medicare Part B drugs to beneficiaries (as well as in other circumstances where assignment is mandatory). This change request will be implemented on November 14, 2005. The change request can be found at: *http://www.cms.hhs.gov/manuals/pm_trans/R643CP.pdf.*

Comment: Several commenters expressed concern that the DMERC Information Form (DIF), which the August 14, 2004 final rule indicated would be eliminated, had not been eliminated yet. A commenter also mentioned some suppliers having difficulty with the rejection of claims for immunosuppressives for ''DIFs not on file,'' when they are on file. In addition, one commenter urged us to not only eliminate the DIF, but also to eliminate the requirement that pharmacies collect and submit the DIF information with each claim. The commenter suggests that most of this information can be obtained by information submitted to Medicare by the transplant facility or transplant physician, and the requirement for pharmacies to submit the information is duplicative.

Response: The elimination of the DIF will be implemented with the quarterly systems release that occurs April 2006. A number of systems issues makes the elimination of the DIF more involved than anticipated. We regret the delay in the elimination of this requirement, and remain committed to implementing the change in April 2006. Regarding the other issues concerning the DIF raised in the comments, these billing issues are outside the scope of this final rule; however, we encourage commenters to continue to bring these concerns to our attention.

Comment: A specialty pharmacy group indicated that some pharmacies had encountered situations where Medicaid or other third party payers were not covering the beneficiary's coinsurance on the supplying fee. The commenter requested that the final rule include an explanation of these parties'

responsibilities concerning beneficiary coinsurance on the supplying fee.

Response: The supplying fee is covered under Medicare Part B. Like all other Medicare Part B benefit categories, standardized Medigap plans are responsible for paying all (plans A–J) or a specified proportion (plans K and L) of a beneficiary's Part B coinsurance once the Part B deductible has been met.

With some exceptions, State Medicaid programs are responsible for beneficiary cost-sharing for the supplying fee for beneficiaries who are dually eligible for both Medicare and Medicaid. State Medicaid programs can limit coinsurance payments to the extent that any payment, when combined with Medicare payments, equals the amount of reimbursement payable under the State Medicaid program. A State Medicaid program may deem a pharmacy to be paid in full even if it has received either no coinsurance payment or a reduced payment from the State. Beneficiaries have no liability beyond the State's payment amount as set forth in section 1902(n)(2) of the Act.

Comment: One commenter suggested that physicians be allowed to bill for the supplying fee for immunosuppressive, oral anti-cancer, and oral anti-emetic drugs. The commenter suggested we could define a pharmacy, for the purposes of the supplying fee, to include physicians acting as pharmacists. As another approach, they suggested we could use our inherent reasonableness authority to extend the supplying fee to physicians.

Response: As we indicated in the CY 2005 final rule, given our understanding of Congressional intent, we do not believe it would be appropriate to pay a supplying fee to physicians. In addition, at this time, we do not have sufficient data to determine if our inherent reasonableness authority would apply in this instance.

Comment: A specialty pharmacy group requested that we include clarification in the final rule concerning whether temporary billing codes for the supplying fee G0369 and G0370 will be replaced with permanent codes.

Response: Effective January 2006, we intend to replace the G-codes for the supplying fee with Q-codes.

6. Competitive Acquisition of Outpatient Drugs and Biologicals Under Part B

In this section of the preamble, we discuss the Competitive Acquisition Program (CAP) for Part B drugs; summarize the requirements established in the July 6, 2005 interim final rule with comment titled ''Competitive Acquisition of Outpatient Drugs and Biologicals Under Medicare Part B'' (70 FR 39022); respond to comments on selected issues in that rule and finalize the associated policies; and discuss the next steps in the implementation of the CAP program. We are addressing the issue of inclusion of CAP drug units in the ASP calculation in separate rulemaking.

General Overview of CAP

Section 303(d) of the MMA amended the Act by adding a new section 1847B, which establishes a program for the acquisition of and payment for competitively biddable Part B covered drugs and biologicals furnished on or after January 1, 2006. Implementation of the CAP will provide physicians with a choice between—

- Obtaining these drugs from entities selected to participate in the CAP in a competitive bidding process; or
- Acquiring and billing for Part B covered drugs under the ASP drug payment methodology.

In our July 6, 2005 interim final rule with comment, we finalized provisions set forth in the Competitive Acquisition of Outpatient Drugs and Biologicals Under Part B proposed rule published on March 4, 2005 in the **Federal Register** (70 FR 10746), but also provided the public an additional opportunity to comment on the final provisions established for the CAP. We codified the requirements and provisions for the CAP in regulations at 42 CFR part 414, subpart K, with § 414.906 through § 414.920 containing requirements for payment under the CAP as follows:

- *Section 414.906 (Competitive acquisition program as the basis for payment).* This section specifies how payment for CAP drugs is determined, including vendor responsibilities for billing, shipment and delivery; computation of the payment amount; substitution of CAP drugs and resupply of a participating CAP physician's drug inventory.
- *Section 414.908 (Competitive acquisition program).* This section specifies the process for a physician to select an approved CAP vendor and the responsibilities of a participating CAP physician, including the specific information that must be included on the prescription order as well as notification and the timeframe for submission of claims. This section also specifies the process for selecting approved CAP vendors, as well as factors that are considered in the selection process such as exclusion under section 1128 of the Act from participation in Medicare or other Federal health care programs.
- *Section 414.910 (Bidding process).* This section outlines the specific criteria for submission of a bidding price for a CAP drug, and specifies what costs should be included in the bid price.
- *Section 414.912 (Conflicts of interest).* This section discusses requirements and standards for conflict of interest that applicants that bid to participate and approved CAP vendors must meet.
- *Section 414.914 (Terms of contract).* This section outlines the contract provisions between CMS and the approved CAP vendor including contract length and termination, and specific requirements the approved CAP vendor must comply with.
- *Section 414.916 (Dispute resolution for vendors and beneficiaries).* This section discusses the process available to an approved CAP vendor and beneficiaries for resolution of denied drug claims, outlining the steps, timeframes and requirements that must be met.
- *Section 414.917 (Dispute resolution and process for suspension or termination of approved CAP contract).* This section discusses the process available to participating CAP physicians for resolution of quality or service issues concerning an approved CAP vendor, including steps and timeframes that are to be followed.
- *Section 414.918 (Assignment) and § 414.920 (Judicial review).* Application of assignment and administrative and judicial review for the CAP are discussed in these sections of the regulation, respectively.

In the July 6, 2005, interim final rule with comment for the CAP published as CMS 1325–IFC, we also defined terms used for the CAP in § 414.902. We also established that for initial implementation, the competitive acquisition area, in which approved CAP vendors supply drugs, will be on a national level and include all 50 States, the District of Columbia, Puerto Rico, and the U.S. territories. In addition, we established a single drug category consisting of approximately 180 drugs commonly provided ''incident to'' a physician's service and included these in the addenda to the July 6, 2005 interim final rule with comment. These drugs represent about 40 percent of the approximately 440 drugs that may be billed ''incident to'' physician services and about 85 percent of physicians' Part B drugs by billed charges, as reflected in our Part B billing data.

Effective August 3, 2005, we suspended the vendor bidding process that began with publication of the July

6, 2005 interim final rule with comment to allow us more time to fully review public comments on the interim final rule with comment and also to further refine the bidding process. We provided notification of the suspension on the CMS Web site *http://www.cms.hhs.gov/providers/drugs/compbid/* and through the pharmacy and physician Listservs. We also announced the suspension of the bid process in the Competitive Acquisition of Outpatient Drugs and Biologicals Under Part B: Interpretation and Correction interim final rule with comment, published on September 6, 2005 in the **Federal Register** (70 FR 52930). In that document, we stated we would publish a final rule for implementing the CAP after we analyzed the additional comments on the July 6, 2005 interim final rule with comment and determined the best manner for improving the efficiency of the CAP and increasing potential participation of both vendors and physicians in the program. We also indicated that we would announce the dates for the new vendor bidding period as well as a special physician election period with the publication of the final rule. As noted earlier in this section of the preamble and as discussed in more detail below, in this final rule with comment, we are addressing certain issues raised by commenters responding to the July 6, 2005 interim final rule with comment. We believe it is critical to address these specific concerns we have identified through review of the comments and finalize or clarify specific policy issues raised to allow us to effectively implement the CAP. Other issues raised by commenters that are not addressed in this final rule with comment will be addressed in future rulemaking, once we have fully reviewed all of the comments not addressed in this rulemaking. Specific information concerning implementation of the CAP, including vendor bidding and physician election are discussed later in this section.

Analysis of and Response to Public Comments

We received a total of 225 timely comments in response to the July 6, 2005 interim final rule with comment (70 FR 39022). Commenters included trade associations, medical societies and organizations, a health insurance company, pharmaceutical manufacturers and wholesalers, specialty pharmacies and pharmacy benefits management groups, as well as practitioners, private citizens and patient advocates, and a member of the Congress. All public comments were reviewed and grouped by related topics and focused on various aspects of the CAP interim final rule with comment. In this final rule with comment, we are responding to comments related to certain aspects of the CAP, and making modifications to the regulation text where necessary so that an improved implementation can be achieved. We will be responding to the remaining comments and issues raised in future rulemaking after we have had the opportunity to fully review those comments and issues. The specific areas being addressed are discussed below.

a. Design of the Program

In this section, we discuss the policy and process for changes to the original CAP Single Drug Category List (Addendum A) and changes in the original New Drugs for the CAP Bidding for 2006 (Addendum B). These changes are reflected in Addendum F and Addendum G of this final rule with comment. We also clarify issues related to drugs included in the CAP and updated certain requirements for bidding. We discuss the process for when and how an approved CAP vendor may request that we approve a change to its CAP drug list. Finally we discuss CAP drug weighting for the single drug category.

(1) Changes to the List of Drugs Supplied Under the CAP

The CAP is intended to provide beneficiaries with access to Medicare Part B drugs and maintain physician flexibility when prescribing medications. In the July 6, 2005 interim final rule with comment, we described how the single drug category list was developed and how newer agents and substitute products could be incorporated into the CAP. In this section of the preamble, we will respond to comments relating to drugs supplied under the CAP.

We developed the single drug category list by developing criteria based on Part B drug utilization. This list was published in Addendum A of the July 6, 2005 interim final rule with comment and contains the majority of drugs that a prospective CAP vendor will bid on. Newer drugs without utilization data were listed in Addendum B—New Drugs for CAP Bidding in 2006 in the July 6, 2005 interim final rule with comment. Development of these lists began with the statutory definition of competitively biddable drugs and biologicals (section 1847B(a)(2) of the Act) and then the application of specific steps described in the July 6, 2005 interim final rule with comment (70 FR 39030) to narrow the list of possible drugs based on utilization and other factors, as described in the interim final rule with comment, that we believe made inclusion of the drug in the CAP drug category appropriate for the initial implementation stage of the CAP. Section 1847B(a)(1)(B) of the Act requires that the Secretary establish categories of drugs that will be included under the CAP, and requires the Secretary to phase-in the program with respect to these categories. The statute also defines ''competitively biddable drugs and biologicals'' for the purposes of the CAP by referring to section 1842(o)(1)(C) of the Act.

Relying on our authority to phase in the CAP drug categories as appropriate, we narrowed our focus to drugs furnished ''incident to'' a physician's service. In response to comments, and in an effort to offer the CAP to as many physicians as possible, we chose not to phase-in the CAP on the basis of drugs typically used by any one particular specialty; however, we realized that certain types of drugs may be better suited for inclusion in early stages of the CAP than others. During our review of comments on the July 6, 2005 interim final rule with comment and subsequent review of the single drug category list published in Addendum A, we became aware of supply issues with one specific drug. These issues have prompted us to make changes to the Single Drug Category List in Addendum A of the interim final rule with comment (included with this rule as Addendum F). We have deleted a HCPCS code (J1710) for a drug that is being phased out of the market and revised the addenda that comprise the CAP drug category to account for upcoming changes to HCPCS codes. Also, before the CAP is implemented, several new permanent HCPCS codes will be approved and several others modified. A number of these newly approved codes would have been included in the CAP drug category identified in our July 6, 2005 interim final rule with comment, had permanent HCPCS codes been available at that time. Therefore, we are amending the list of drugs published in the New Drugs for CAP Bidding for 2006 in Addendum B of the interim final rule with comment to account for drugs in the new HCPCS codes, and to account for HCPCS codes that appeared in Addendum A of the July 6, 2005 interim final rule with comment that have since been split into separate HCPCS codes for which we are unable to calculate new weights. Updated lists of drugs that are included in the initial CAP drug category appear

in Addendum F and Addendum G of this rule.

(a) Changes to the Single Drug Category List—Addendum A of the July 6, 2005 Interim Final Rule With Comment

The July 6, 2005 interim final rule with comment discussed criteria for developing the Single Drug Category List (Addendum A of the interim final rule with comment). In the following section, we describe factors that led us to revise this list.

After suspending the bidding process, we reviewed the drugs included in the Single Drug Category List that was published in Addendum A of the July 6, 2005 interim final rule with comment (70 FR 39101). During this process, we found that the brand name product under HCPCS code J1710 (hydrocortisone sodium phosphate injection) was withdrawn from the market and that generic products for this code are not reliably available. This drug's weight in the CAP's Single Drug Category List as published in Addendum A is 0.000060285401. Because of the availability issue associated with this drug we will remove J1710 from the Single Drug Category List and recalculate weights for the remaining drugs. The impact on other drugs' weights will be minimal because of J1710's very low weight.

Yearly updates to the HCPCS codes also impacted the CAP drug lists in several ways. One code J7051 Sterile saline or water up to 5cc (CAP weight = 0.006953978284) was modified to A4218 Sterile saline or water, metered dose dispenser, 10 ml. ''A codes'' are primarily medical and surgical supplies, and we believe that the change reflects usage that is primarily through a means other than incident to a physician's service. Therefore, we will remove this code from the Single Drug Category list and recalculate weights for the remaining drugs.

Revisions to the Single Drug list also reflect modifications to several HCPCS codes. These modifications will not affect the weighting calculation because they are either changes in names or consolidation of multiple codes into one. The previous codes' utilization data will be used in the updated calculation. Table 23 illustrates the affected HCPCS codes.

TABLE 23

New HCPCS code	New description	Old HCPCS code
J0881	Injection, darbepoetin alfa, 1 microgram (non-esrd use)	J0880 Q0137
J0885	Injection, epoetin alfa, (for non-esrd use), 1000 units	Q0136
J7318	Hyaluronan (Sodium Hyaluronate) or derivative, intra-articular injection, 1 mg	J7317 J7320

The changes to the HCPCS codes also affected iron dextran. A discussion of iron dextran's removal from the single drug category list and the addition of the two new iron dextran HCPCS codes to the Revised New Drugs for CAP Bidding For 2006 appears in the following section.

(b) Changes to New Drugs for CAP Bidding for 2006—Addendum B of July 6, 2005 Interim Final Rule With Comment (See Addendum G in This Final Rule With Comment)

Addendum B, published in the July 6, 2005 interim final rule with comment (70 FR 39102), was developed in response to comments on the proposed rule that urged us to provide a means to include newer drugs. We are updating Addendum B with drugs that have been recently assigned new HCPCS codes, and drugs that were previously listed in Addendum A of the July 6, 2005 interim final rule with comment, but because of HCPCS code changes, cannot be re-weighted. These changes appear in Addendum G of this rule. Further details are provided below.

Comment: We received numerous comments asking that individual drugs that were recently approved and introduced to the United States market be included in the CAP. Improving the selection of products that could be supplied through the CAP was commonly given as a reason for the request.

Response: We agree that it is desirable for the CAP to include a wide variety of drugs and to maintain the flexibility to adapt to a rapidly changing marketplace. Therefore, we are adding additional procedures to the CAP that will allow approved CAP vendors to adjust and update their drug lists. These changes are described below.

In the July 6, 2005 interim final rule with comment, we stated that we intended to provide the physician with choice and flexibility within groups of drugs that might be used by different specialties for the treatment of various conditions. The drugs available under the CAP are intended to accommodate a variety of physician practice patterns and a variety of specialties. As discussed in other sections of this rule, the CAP also seeks to provide access to new drug therapies.

As a part of the annual HCPCS code update, several new permanent HCPCS codes were issued. Billing with these codes will begin on January 1, 2006. In order to keep the CAP list of drugs as comprehensive and complete as possible, we have updated the New Drugs for CAP Bidding that was originally published in Addendum B of the July 6, 2005 interim final rule with comment to account for the coding changes. This list of newly issued HCPCS codes provided us with an opportunity to add drugs to the CAP drug category; the additions include several recently approved drugs. Examination of the new HCPCS codes also revealed that several codes for drugs listed in Addendum A of the July 6, 2005 interim final rule with comment had undergone modification. For example, beginning in January 2006, the HCPCS code for iron dextran will be split into two codes, and the HCPCS code for darbepoetin alfa when used for non-end stage renal disease will be revised.

We are unable to recalculate the weights for these split HCPCS codes because it is not possible to estimate the new codes' utilization. Therefore, we are including these drugs in a revised version of Addendum B—New Drugs for CAP Bidding 2006, which was published in the July 6, 2005 in the interim final rule with comment. The list of New Drugs for CAP Bidding 2006 is now Addendum G of this rule. We believe this change is appropriate because we had already decided to include these drugs in the CAP drug category, and adding them to Addendum G will avoid a recalculation of the other CAP drugs' weights based on an imprecise estimate of utilization. Addenda F and G published in this final rule with comment supersede Addenda A and B from the July 6, 2005 interim final rule with comment. Note that HCPCS code modifications as they

relate to the Single Drug Category list were discussed in section II.H.6.a.(1).(a) of this final rule with comment.

In order to be included in Addendum G—Revised List of New Drugs for CAP Bidding for 2006, we determined that a drug must not appear in the Revised Single Drug Category List (Addendum F of this rule) and must meet at least one of the following three criteria:

• Criterion 1: The drug must have been listed in Addendum B of the July 6, 2005 interim final rule with comment, ''New drugs for CAP Bidding for 2006''.

• Criterion 2: The drug must have a new J or Q HCPCS code effective January 1, 2006, and meet the three following conditions:

+ Be administered incident to a physician's service.

+ Have had a previous C, S or ''NOC'' (Not Otherwise Classified or Miscellaneous) code.

+ Have one national published ASP payment price and not meet either of the following two conditions:

++ Be primarily billed through the DME process.

++ Be primarily used as a diagnostic agent.

• Criterion 3: The drug must be listed in Addendum A—Single Drug Category List published in the July 6, 2005 interim final rule with comment, but had its HCPCS code terminated effective January 1, 2006 and split into J or Q Codes that become effective January 1, 2006.

Criterion 1 describes drugs listed in Addendum B of the July 6, 2005 interim final rule with comment. Tables 24 and 25 list drugs that meet criteria 2 and 3. Table 24 lists drugs that will have new HCPCS codes beginning January 1, 2006 and Table 25 is a list of drugs that were previously included in Addendum A but whose HCPCS codes were split. Combining these three lists will yield Addendum G—Revised New Drugs for CAP Bidding for 2006, which is published in this rule.

TABLE 24.—CAP DRUGS WITH NEW HCPCS CODES EFFECTIVE JANUARY 1, 2006

HCPCS (effective 1/1/2006)	Long description
J0128	Abarelix injection.
J0180	Agalsidase beta injection.
J0878	Daptomycin injection.
J1931	Laronidase injection.
J2357	Omalizumab injection.
J2469	Palonosetron HCl.
J2794	Risperidone, long acting.
J9035	Bevacizumab injection.
J9041	Bortezomib injection.

TABLE 24.—CAP DRUGS WITH NEW HCPCS CODES EFFECTIVE JANUARY 1, 2006—Continued

HCPCS (effective 1/1/2006)	Long description
J9055	Cetuximab injection.
J9305	Pemetrexed injection.
J9264	Paclitaxel protein bound particles.
J2503	Pegaptanib.
J0278	Amikacin.
J9225	Histrelin implant.

TABLE 25.—HCPCS CODES FROM ADDENDUM A THAT HAVE BEEN SPLIT

HCPCS (effective 1/1/2006)	2006 Long description	Discontinued HCPCS
J1751 ..	Iron Dextran 165.	J1750
J1752 ..	Iron Dextran 267.	J1750

The drugs identified in Addendum G will be bid and paid for as described in the July 6, 2005 interim final rule with comment (70 FR 39072). In the July 6, 2005 interim final rule with comment, we stated that we will require that prospective vendors include bids for all of these drugs in their submissions and provide these drugs to physicians who elect to participate in the CAP. However, we will not incorporate the bids for these drugs into the composite bid methodology, because we lack sufficient utilization data to compute appropriate weights for these drugs. Instead, we will consider these bids separately from, but parallel to, evaluation of the composite bid for the other drugs for which we have adequate utilization data. Specifically, we will require bidders to submit a separate bid for each drug in the list. We will also impose a ceiling on acceptable bids. As in the case of the composite bids, that ceiling will be tied to the ASP payment methodology. Specifically, we will not accept any bid for a drug listed in Addendum G that is higher than 106 percent of the ASP for that drug (as determined at the time when the bidding begins). In order to be eligible for selection as an approved CAP vendor, a bidder must meet all of the criteria outlined in § 414.908 of the regulation text and must submit acceptable bids on each of the drugs listed in Addenda F and G of this final rule with comment.

(c) Process for Adding NDCs Within a HCPCS Code in an Approved CAP Vendor's Drug List

We acknowledge that given the 3-year CAP contract duration, some changes to the approved CAP vendors' CAP drug lists are anticipated during the life of the contract. In the July 6, 2005 interim final rule with comment (70 FR 39075), we described a mechanism where approved CAP vendors could request CMS approval to add new drugs to their CAP drug lists once the drug had a permanent HCPCS code. We also described a mechanism (70 FR 39044 and § 414.906(f)(2)(i)) where, if a particular NDC becomes unavailable or goes through a period of short supply an approved CAP vendor could substitute a different NDC within the HCPCS code for the NDC currently supplied by the approved CAP vendor for an extended period of time (2 weeks or longer) if the approved CAP vendor identifies the replacement product, CMS approval for the substitution is obtained, and all participating CAP physicians who have selected the approved CAP vendor are notified of the change.

Comment: Numerous commenters recommended that we develop a mechanism to allow approved CAP vendors to add drug products (identified by an NDC) to those already supplied within a HCPCS code during the CAP contract period. Potential vendors indicated in their comments that they would like the flexibility to add NDCs because, as experience with the CAP grows, they may encounter situations where the addition of certain drugs supplied under a HCPCS code may improve beneficiary access, reduce waste, and improve the vendor's cost efficiency.

Response: We agree that additional mechanisms to expand an approved CAP vendor's drug list at the NDC level are desirable. The current requirements state that an approved CAP vendor must offer at least one NDC within each HCPCS code in the CAP drug category. We encourage potential vendors to bid more than the minimum of one NDC per HCPCS code. However, we also understand that, as the 3-year contract period progresses, opportunities to modify the initial list of NDCs supplied under a HCPCS code will occur. Examples of these opportunities could include introduction of a new package size, the introduction of a new manufacturer's products (including new multisource products), and price changes in existing NDCs.

We believe that in order for an approved CAP vendor to continue to meet participating CAP physicians'

needs, it is in the approved CAP vendor's best interest to provide and maintain a satisfactory range of products, and to improve the range of available products as experience with the program increases. We agree that a mechanism to increase the number of CAP drugs offered by an approved CAP vendor is expected to improve access to Part B drugs and to improve prescribing flexibility for physicians who obtain drugs through the CAP. We believe that the process to add NDCs to the existing list of NDCs supplied by an approved CAP vendor is appropriate, provided that the additions to the approved CAP vendor's list undergo an approval process.

In the July 6, 2005 interim final rule with comment, in § 414.906(f)(2), we stated that the designated carrier's medical director will approve long-term substitutions to the list of drugs supplied by an approved CAP vendor ''on behalf of CMS.'' As described in the following sections of this rule and based on comments on the interim final rule with comment, we have expanded this request and approval process for incorporating changes into the list of drugs supplied by the CAP vendor to include new NDCs, and new HCPCS codes. In addition, beginning in 2007, approved CAP vendors will be able to request approval to add newly approved drugs to their CAP drug list before the drug is assigned a HCPCS code.

In order to provide flexibility for managing this task and consistency for these processes, we are amending § 414.906 to allow CMS or its designee to approve long-term substitutions and additions to approved CAP vendors' CAP drug lists. We are also revising § 414.906(f)(4)(iii) to specify that substitutions that are due to a drug shortage, or other exigent circumstance, may become effective immediately provided that the approved CAP vendor's participating CAP physicians are notified of the substitution immediately following CMS approval.

We are modeling the process of adding new NDCs within a HCPCS code on the substitution mechanism described in the July 6, 2005 interim final rule with comment (70 FR 39044) and specified in § 414.906(f). We note that because this is a mechanism for the addition of drugs to an approved CAP vendor's CAP drug list, the approved CAP vendor will be required to continue supplying all NDCs from its most recently updated CAP drug list. (The substitution process should be used if the approved CAP vendor is seeking approval to remove an NDC from its CAP drug list and replace it with another NDC.) In order to add a new NDC within a HCPCS code being offered in the approved CAP vendor's CAP drug list, the approved CAP vendor must make a written request to CMS or its designee. Requests for approval must include a rationale and discussion of impact on the CAP, including safety, waste, and potential for cost savings. The requests will be reviewed and, if approved, changes will become effective as of the beginning of the next quarter.

Like the substitution procedure, the addition of new NDCs to an approved CAP vendor's CAP drug list will not affect the CAP payment amount for that particular HCPCS, as the payment amount will have been set during the initial bidding (or approval process for adding an additional HCPCS code) and, if applicable, updated as outlined in § 414.906. This application process is reflected in the amended § 414.906(f)(2)(ii).

Participating CAP physicians who have selected the approved CAP vendor must be notified of additions to the approved CAP vendor's CAP drug list at least on a quarterly basis (at least 30 days or earlier before the approved changes are due to take effect). Both the approved CAP drug vendor and CMS (or its designee) will be responsible for maintaining this information and disseminating it. Approved CAP vendors must provide direct (for example, mail or e-mail) notification of updates to the participating CAP physicians enrolled with them on a quarterly basis. The entire list of drugs supplied by the approved CAP vendor should be disseminated at least once yearly; and approved CAP vendors must make a complete list that incorporates the most recent updates available to participating CAP physicians on an ongoing basis. We will post the updated drug lists on our web site. The approved CAP vendor may also post the complete, updated, and approved list on its web site. We have added these requirements to new § 414.914(f)(15). We will issue additional instructions for this process at a later date.

(d) Process for Expediting the Addition of Newly Approved Drugs to the CAP (''NOC'' Codes)

The July 6, 2005 interim final rule with comment outlined a process that approved CAP vendors can use to add new drugs to the list of drugs supplied under the CAP once the new drug has been assigned a permanent HCPCS code, provided the drug would have been properly assigned to the single drug category and that CMS determines that the drug is appropriate for inclusion. This mechanism was intended to provide an opportunity for vendors to supply drugs that were introduced too late to be incorporated into the Addendum B—New Drugs for CAP bidding for 2006 published in the July 6, 2005 interim final rule with comment.

Comment: Several commenters have requested that we develop a process to further expedite the addition of newly approved or marketed drugs to an approved CAP vendor's drug list. Commenters stated that access to newly approved drugs should be immediate. These commenters further stated that participating CAP physicians should not have to go outside of the CAP to acquire new drugs. Several commenters suggested a mechanism that uses the miscellaneous (''NOC'') HCPCS codes for physicians and vendors to bill CAP drugs that do not have a permanent HCPCS code. Certain commenters also suggested that approved CAP vendors be required to offer the new drugs as soon as they are on the market.

Response: We agree with the commenters that the earlier addition of newly approved or newly marketed drugs to the CAP is desirable, to the extent these drugs are appropriate for inclusion in the CAP. The tight timeframe for CAP implementation and the requirement for additional system changes prevent us from implementing the process suggested by the commenters at this time. In 2007, approved CAP vendors will be able to request CMS approval to add new drugs without a permanent HCPCS code to their CAP drug lists. This process will be similar to the process established in the July 6, 2005 interim final rule with comment that allows approved CAP vendors to add new drugs that are assigned a permanent HCPCS code to their CAP drug lists. Approved CAP vendors will submit a request to add these drugs, and CMS or its designee will determine whether the particular drugs are appropriate for inclusion in the CAP using a process that parallels the development of the Single Drug Category List and the List of New Drugs for CAP bidding for 2006. Updates to the approved CAP vendors' CAP drug lists will be made on a quarterly basis; we anticipate that all approved CAP vendors' updates will be posted on the CMS Web site simultaneously.

Payment for new CAP drugs approved for inclusion in the approved CAP vendor's CAP drug list before they are assigned a HCPCS code would be at the price published in the ASP's ''not otherwise classified'' (NOC) price file consistent with the next quarterly update. And we note that these drugs would be considered for inclusion in the CAP only if CMS is able to identify

a single ASP payment amount for the drug. At a future date, we will issue additional guidance to approved CAP vendors on the application procedures for requesting approval to add these changes to the approved CAP vendor's CAP drug list, and we will issue additional guidance to participating CAP physicians on how to order these particular drugs once they are added to the approved CAP vendor's CAP drug list.

We do not believe that requiring approved CAP vendors to add all new drugs to their CAP lists is advisable. Instead, we believe that a request and approval process as described for other changes to an approved CAP vendor's drug list would be appropriate because it would allow for flexibility while ensuring that only those that are appropriate for inclusion in the CAP are added to an approved CAP vendor's CAP drug list. As discussed in the July 6, 2005 interim final rule with comment (70 FR 39027 through 39031) some drugs may not be good candidates for the CAP, for instance, some new drugs are not typically administered ''incident to'' a physician's services, some new drugs may have very low utilization, and some may have special storage, distribution, or handling requirements that would make these drugs inappropriate for inclusion in the CAP. The existing procedures for adding new NDCs within the HCPCS codes that are on an approved CAP vendor's CAP drug list, and the new procedures for adding new HCPCS codes to an approved CAP vendor's CAP drug list also rely on approved CAP vendors' voluntary requests and our approval of these requests. Simply put, we want to expand the number of CAP drugs that approved CAP vendors offer, but we do not believe that all new drugs should be added to the CAP, or that addition of certain drugs should be mandatory, especially at the beginning of this program. As we gain experience with the program we may consider other approaches to the addition of drugs that a vendor supplies under the CAP.

Beginning in 2007, approved CAP vendors will be able to request approval to add new ''NOC'' drugs to their CAP drug lists. The procedures will parallel those for addition of new HCPCS codes and new NDCs within a HCPCS code, as specified in § 414.906(f)(2)(iv). In each case, the approved CAP vendor must make a written request to CMS (or its designee). Requests for approval must include a rationale and discussion of impact on the CAP, including safety, waste, and potential for cost savings. The requests will be reviewed and, if approved, changes will become effective on a quarterly basis.

We remind physicians that an approved CAP vendor's CAP drug list is subject to change over the contract period. Upon electing to participate in the CAP and selecting an approved CAP vendor, participating CAP physicians are agreeing to accept, in most cases, the particular NDCs listed and shipped by the selected approved CAP vendor for the duration of the participating CAP physician's election period with the approved CAP vendor. By electing to participate with a particular approved CAP vendor, the participating CAP physician also is agreeing to accept the approved changes to the approved CAP vendor's CAP drug list and drugs supplied under the updated and approved lists. We believe that the changes in the approved CAP vendor's CAP drug list will improve (or at least maintain) a participating CAP physician's selection of available drugs and will likewise improve (or maintain) Medicare beneficiaries' access to drugs supplied under the CAP. We are revising § 414.908(a)(3)(vi) to state this requirement.

We remind physicians that routine orders for CAP drugs should be placed at the HCPCS level, unless the participating CAP physician determines that a particular product that is on the approved CAP vendor's CAP drug list is medically necessary for a patient. In this case, a participating CAP physician may order that specific NDC from the approved CAP vendor under the ''furnish as written'' process. Documentation of medical necessity in the medical record is also required; this information may be subject to medical review. We are revising § 414.908(a)(3)(vii) to reflect this requirement.

(e) Process for Adding Drugs With a New HCPCS Code to the CAP

In the July 6, 2005 interim final rule with comment (70 FR 39075), we stated that we would allow approved CAP vendors to petition CMS to add drugs with a new HCPCS code to their CAP drug lists; however, we did not include regulation text to implement this section. In order to implement this process we are amending regulation text at § 414.906(f)(2)(iii).

(f) Process for Adding Single Indication Orphan Drugs to the CAP

Table 26 is a brief summary of methods that an approved vendor may use to amend the list of drugs it supplies under the CAP. Please note that all of these methods require approval from CMS or its designee.

Comment: We received several comments from manufacturers requesting inclusion of their single indication orphan drugs in the CAP. Most commenters stated that these low volume products were quite suitable for the CAP because availability through the CAP would minimize the associated administrative burden for physicians who choose to administer them. Inclusion of one product (thyrotropin alfa) was also requested by a number of physicians who treat patients with thyroid cancer and by patients who had been treated for thyroid cancer. One manufacturer specifically requested that its orphan drug (azacitidine) not be included in the CAP, citing concern about timely access to the drug.

Response: We appreciate the comments that we received regarding single indication orphan drugs. Improving access to Part B drugs is a desirable quality for this program. For example, we have endeavored to improve access by allowing the addition of new NDCs and new HCPCS codes to a drug vendor's list. During this initial stage of the CAP, as described in the July 6, 2005 interim final rule with comment (70 FR 39032), we also have sought to strike a balance that would allow for a sufficiently sized market volume for approved CAP vendors, while making the CAP a meaningful alternative for most physician specialties. In order to decrease the inventory burden for approved CAP vendors, we wanted to minimize the number of drugs included in the CAP drug category that are billed in very low volumes, so we applied dollar value thresholds to the CAP.

As noted by commenters, the addition of the single indication orphan drugs to the CAP drug category may decrease administrative burden on the participating CAP physicians, and we agree that a decreased burden is desirable. We are persuaded by the number of commenters that asked us to include single indication orphan drugs in the CAP drug category that a mechanism for their addition to an approved CAP vendor's CAP drug list is desirable. However, for the reasons that prompted us not to include single indication orphan drugs in the initial drug category (as described in the July 6, 2005 interim final rule with comment), we continue to believe that we should not require approved CAP vendors to supply these drugs.

Therefore, we are specifying that approved CAP vendors may request CMS approval to add single indication orphan drugs (as described in the July 6, 2005 interim final rule with comment) to their CAP drug lists. The

single indication drugs covered by this provision are the following: J0205, J0256. J9300, J1785, J2355, J3240, J7513, J9010, J9015, J9017, J9160, J9216 and their successor codes. Payment for single indication orphan drugs that vendors voluntarily add to the CAP will be based on ASP+6 percent.

TABLE 26.—METHODS FOR CHANGING AN APPROVED CAP VENDOR'S CAP DRUG LIST

Description	Regulation text
Substitution: Approved CAP vendor may request approval to replace one or more NDCs in a HCPCS code supplied by the approved CAP vendor with one or more other NDCs.	§ 414.906(f)(2)(i).
Add newly issued HCPCS Codes: Approved CAP vendor may request that CMS allow it to supply additional HCPCS codes under the CAP.	§ 414.906(f)(2)(iii).
Additional NDCs: Approved CAP vendor may request that CMS allow it to supply additional NDCs under a HCPCS code that the approved CAP vendor already supplies under the CAP.	§ 414.906(f)(2)(ii).
Newly approved drugs without HCPCS codes (''NOC'' dugs''): Beginning in 2007, approved CAP vendor may request that CMS allow it to supply a newly approved drug under the CAP before a permanent HCPCS code is assigned to the drug.	§ 414.906(f)(2)(iv).
Single Indication Orphan Drugs: Approved CAP vendor may request that CMS allowed it to supply single indication orphan drugs under the CAP.	§ 414.906(f)(2)(iii).

(g) Other Issues Related to Drugs Supplied Under the CAP

(i) Addition of Other Specific Drugs

We received comments regarding the addition of low volume drugs, and dermal tissue biologicals to the CAP. Specific comments and responses for each type of drug follow.

Comment: One commenter asked whether we would allow approved CAP vendors to voluntarily supply drugs with low utilization volumes through the CAP. The commenter was specifically referring to drugs that were not included in the CAP category because of utilization criteria described in the interim final rule with comment (70 FR 39031–39032).

Response: Drugs included in the initial CAP drug category account for about 85 percent of Part B drugs billed by physicians. In other sections of this rule we have described methods that an approved CAP vendor may use to request the addition of new NDCs or new HCPCS codes to the CAP. Although we appreciate the request to add drugs with low utilization volumes to the CAP drug category, we believe it is appropriate to allow additions to an approved CAP vendor's CAP drug list through the case-by-case approval process we have described above and specified in § 414.906. Once we gain experience with the CAP, we anticipate being able to consider broadening the scope of drugs included in future CAP drug categories.

Comment: The manufacturers of two dermal tissue products expressed concern about language in the July 6, 2005 interim final rule with comment that stated ''tissues are not considered drug products.'' One manufacturer asked that its product be included in the CAP, while the other stated other reasons for excluding its product were appropriate and did not ask that its product be included in the CAP.

Response: We thank the commenters for providing us with the opportunity to clarify the discussion about dermal tissue found in the July 6, 2005 interim final rule with comment (70 FR 39031). During development of the criteria used to create Addendum A—Single Drug Category List of the July 6, 2005 interim final rule with comment, we attempted to allow for a sufficiently sized market for approved CAP vendors, while making the CAP a meaningful alternative for most physician specialties. The statement that the commenter references above was intended to explain why we did not include dermal tissue products in the initial CAP drug category and was not intended to reflect overall Medicare policy for dermal tissue products. We are not including tissues in the initial CAP drug category at this time because the products do not have sufficient documented utilization, and some products may require specialized handling. As we gain experience with the CAP, we anticipate reevaluating exclusion criteria applied to bidding for the initial phase of this program.

(ii) Formularies and the CAP

In the July 6, 2005 interim final rule with comment, we responded to comments on the subject of formularies. We respond to additional comments on the subject from the July 6, 2005 interim final rule with comment below.

Comment: We received several comments that encouraged us to refrain from creating formularies in the CAP and to avoid situations where a formulary-like process could be created. Commenters raised concerns about a formulary's likelihood to limit beneficiaries' access to a wide selection of drugs and the impact on a physician's choice in prescribing medications.

Response: In the July 6, 2005 interim final rule, we stated that we were not accepting the recommendation that vendors be permitted to establish formularies because the statute expressly requires that for multiple source drugs, a competition be conducted for the acquisition of at least one drug per billing code within that category (70 FR 39034). We agree that in an effort to provide physicians with maximum flexibility in prescribing, we should avoid the use of formularies in the CAP. Furthermore, we believe that making the CAP less restrictive will increase physician interest and, therefore, improve vendor participation.

In the July 6, 2005 interim final rule with comment (70 FR 39033 through 39034 and 39068), we stated that ''we do not expect there to be a creation of a drug formulary,'' and we further discussed our belief that vendors would find it prudent to structure their bids in a way to supply more than one NDC per HCPCS code. We wish to emphasize that this is still our position on formularies in the CAP. It is our opinion that approved CAP vendors who offer more than one product per HCPCS code would be selected by a greater number of participating CAP physicians.

(iii) Physicians Regulatory Issues Team Drugs

The July 6, 2005 interim final rule with comment also discussed issues regarding drugs that have posed acquisition problems for some physicians under the ASP system. We received additional comments on this topic.

Comment: Commenters asked whether drugs included on the Physicians Regulatory Issues Team (PRIT) list (drugs reported to be difficult for physicians to obtain for less than ASP+6 percent) have been included in the CAP. Commenters also asked that

the PRIT list be made available to the public.

Response: The PRIT is a group of CMS subject matter experts who work to reduce the regulatory burden on Medicare physicians. Since the inception of the ASP payment system, individual physicians have reported difficulty in acquiring certain drugs for less than ASP+6 percent. At the request of the Physicians Practice Advisory Committee, the PRIT began compiling reports of these situations. More information about the PRIT may be found at the following web site: *http://www.cms.hhs.gov/physicians/prit/.*

Because the PRIT list is based on voluntary reporting, and information is received on an ad-hoc, nonrepresentative basis, the PRIT list may not fully describe overall drug pricing or availability patterns; therefore, we have chosen not to use the PRIT list as a specific criterion for the CAP. However, as stated in of the July 6, 2006 interim final rule with comment (70 FR 39033), we did review drugs that had been associated with access problems under the ASP payment system during the development of the CAP single drug category and we have subsequently examined the PRIT list during the writing of this rule. We have found that the CAP includes most drugs reported to the PRIT. PRIT list drugs not in the CAP are drugs that were not included for specific reasons described in the July 6, 2005 interim final rule with comment, such as -single indication orphan drugs, drugs without permanent HCPCS codes, oral medications, and drugs with low utilization.

(iv) Discussion of Intrathecal Pain Management

The July 6, 2005 interim final rule with comment's discussion of specific drugs contained a comment and response on ziconotide (Prialt®).

Comment: One commenter stated that, in our discussion of intrathecal pain management, we mischaracterized ziconotide as an opioid analgesic. The commenter points out our inconsistency in referring to ziconotide as an opioid, but following with a discussion that demonstrates understanding that ziconotide is not an opiate. The commenter asked if non-opiate pain medications administered intrathecally through an implanted pump or external infusion device would be suitable for inclusion in the CAP. The commenter also asked whether ziconotide could be added to Addendum B—New Drugs for CAP Bidding for 2006 of the drug bidding list if a permanent HCPCS code were assigned in the Fall of 2005. The commenter also noted that baclofen and clonidine, two other medications that can be administered intrathecally through a pump, are included in the CAP drug category.

Response: We appreciate the opportunity to clarify our discussion. Ziconotide is not an opiate analgesic and it is not a controlled substance. Neither the comment nor the corresponding response were intended to describe ziconotide as an opioid or to limit the discussion to intrathecally administered opioids.

Our response to the comment in the interim final rule with comment was intended to address two points. First, we did not consider opioids and ziconotide for inclusion into the bid list for different reasons. Opioids are controlled substances and are subject to extra record keeping requirements as stated in the July 6, 2005 interim final rule with comment (70 FR 39028); ziconotide was not included in the CAP drug category because it had not yet been assigned a HCPCS code. Second, we agreed in principle that opioid medications administered intrathecally through implanted variable-rate infusion devices could be included under the CAP, when they are administered by physicians in their offices incident to their services. Although we specifically referred to opioid medications in this discussion, the statement applies to non-opioid medications as well. However in the interim final rule with comment, we described our methodology for determining whether a drug would be included in the initial CAP drug category. (70 FR 39028 and 39031 through 39032).

Although ziconotide generally appears to meet the criteria for inclusion in the initial CAP drug category, we have become aware of an unresolved payment methodology issue with this drug resulting in the lack of a consistent ASP for ziconotide. It is important that drugs included in the CAP drug category have an ASP that we can determine, because a drug's ASP is used to calculate the overall price ceiling for the composite bid and the maximum payment amount for CAP drugs not included in the composite bidding process. For this reason, we are not including this drug in the CAP at this time.

(v) Leuprolide and Related Drugs

During the development of the Single Drug Category List published in Addendum A of the July 6, 2005 interim final rule with comment, we chose not to include injectable forms of leuprolide acetate (J9217 and J9218) in the initial CAP drug category. We provide a discussion of local coverage determinations (LCDs) and LCA policy as it relates to the CAP in the July 6, 2005 interim final rule with comment (70 FR 39039). We note that leuprolide acetate implant (J9219) remains in the CAP's Single Drug Category List.

Comment: We received several comments about leuprolide and other luteinizing hormone-releasing hormone (LHRH) analogues, which include goserelin, triptorelin, and histrelin. Commenters acknowledged the complexity of applying LCA policies to the CAP for both physicians and vendors. They also questioned whether all regions of the United States were subject to LCA policies for this leuprolide, and commenters expressed concern that the policies may extend to LHRH other than leuprolide and goserelin, such as histrelin and triptorelin. Two commenters suggested that the CAP not use LCA policies, and failing that the commenter suggested that drugs covered by LCA policies be ''carved out'' of the CAP. Another commenter stated that LCA policies varied so much that not including leuprolide in the CAP drug category was an incomplete solution to the LCA issue because the entire group of LHRH analogues was in the process of becoming affected by LCAs, and that continuing price changes could not guarantee that goserelin would remain the least costly alternative drug among the LHRH analogues.

Response: We appreciate the concerns raised by the commenters. However, we do not believe that we have the authority to specify that CAP prices supersede an LCA policy. As we stated in the July 6, 2005 interim final rule with comment, nothing in this rule is intended to disrupt the longstanding ability of contractors to apply an LCA policy under section 1862(a)(1)(A) of the Act. Section 1862(a)(1)(A) of the Act provides that notwithstanding any other provision in the Medicare statute (that is, including section 1847B of the Act), no payment may be made under Part A or Part B for any expenses incurred for items and services that are not medically necessary. As a result, if a carrier applies an LCA policy to a particular drug, a claim submitted to the carrier for that drug is subject to LCA.

After considering the comments, we continue to believe that the decisions outlined in the July 6, 2005 interim final rule with comment pertaining to which drugs are included in the CAP drug category maintain a balance between physician access to LHRH analogues

and vendor risk associated with the application of LCAs for these drugs.

(h) Drug Weighting

In the July 6, 2005 interim final rule with comment (70 FR 39069), we finalized our proposal to employ a ''composite bid'' for selecting bidders. The composite bid will be constructed by weighting each HCPCS bid by the HCPCS code's share of volume (measured in HCPCS units) of drugs in our single drug category during the prior year. Within the single category, the drugs weights will sum to one.

Comment: Some commenters suggested that instead of using only utilization data to derive weights, we should use both utilization and allowed charges data so that products with high utilization, but low charges, are not over weighted.

Response: We appreciate the suggestion of an alternative weighting methodology, and we recognize that the weighting methodology could be developed in a number of ways. We are also aware that changing the weighting methodology from utilization volume to dollar volume could impact overall weighting.

For the initial bidding cycle, we chose to use a relatively simple weighting methodology based on claims volume, but corrected for the appearance of multiple identical claim lines on a given day of service. We also believe that the creation of a single drug category further minimizes some effects associated with using utilization data as the only weighting parameter. We do not believe that a change in weighting methodology would result in significantly different weights than those derived under the current weighting methodology for the majority of drugs in the single drug category list. Therefore, we will implement CAP using the same weighting methodology described in the July 6, 2005 interim final rule with comment (70 FR 39069 through 39071) and will consider alternatives for future bidding cycles.

Earlier in this section we have discussed the need to make changes to the Single Drug Category List published in Addendum A of the July 6 2005 interim final rule with comment. The resulting change in the composition of the Single Drug List required us to recalculate the drug weights. A complete discussion of the reasons for this revision is included in section II.H.6.a.(1)(a), Changes to the Single Drug Category List—Addendum A of the July 6, 2005 interim final rule with comment.

b. Vendor/Bidding Issues

In this section we discuss issues related to vendor bidding such as drug quality, vendor subcontracting, confidentiality of the bids, vendor call center requirements, the inclusion of prompt pay discounts in vendor net acquisition costs, and the mechanics of the bidding process.

(1) Quality/Product Integrity

In the July 6, 2005 interim final rule with comment (70 FR 390660 through 390662), we discussed product integrity and the requirement to comply with existing State and Federal laws regarding adulteration, misbranding, spoilage, contamination, expiration, and counterfeiting of products. We stated that although we do not propose to require applicants or potential CAP vendors to employ measures beyond those required for licensure and regulatory compliance, we believe these measures set a minimum standard, and we requested that applicants discuss any additional measures they have taken to ensure product integrity. We also provided examples of additional measures that pose minimal burden but enhance the ability to detect adulterated, misbranded, or counterfeit drugs. We further stated that the approved CAP vendor application process, the maintenance of appropriate licensure, and Medicare supplier status form the framework for product integrity. We also noted that potential CAP vendors are required to submit a compliance plan as part of the bidding process that contains policies and procedures for the prevention of fraud, waste, and abuse, and provides detailed information on steps to ensure product integrity as specified in § 414.914.

Comment: Many commenters supported the steps outlined in the July 6, 2005 interim final rule with comment to ensure quality and product integrity. There were some commenters, however, who expressed concern that the provisions in the interim final rule with comment will not be adequate to prevent fraud and abuse and ensure product integrity. One commenter believed that patient health and safety could be compromised by the imposition of a third party (the approved CAP vendor) for drug acquisition, preparation, and delivery. This commenter was also concerned about the possibility that certain drugs could be reconstituted in their vials by the approved CAP vendor. Another commenter suggested that the Verified-Accredited Wholesale Distributors ™ Program could play a key role in adherence to quality and performance standards among approved CAP vendors. This is a program developed by the Task Force on Counterfeit Drugs and Wholesale Distributors that was convened in 2003 by the National Association of Boards of Pharmacy to ensure that a wholesale distribution facility is licensed and operating under best practices for drug distribution.

Response: We appreciate and share the commenters' concerns about ensuring quality and product integrity. However, we do not agree that the approved CAP vendor's role in drug acquisition, preparation, and delivery will compromise patient health and safety. We addressed the issue of reconstituted vials in the July 6, 2005 interim final rule with comment (70 FR 39061) by stating that approved CAP vendors may split vial trays, but cannot ship opened vials.

As we gain more experience with the CAP, we will explore the Verified-Accredited Wholesale Distributors ™ Program and other options to further protect product integrity.

Comments: Several commenters recommended that CMS establish standards and survey procedures for approved CAP vendors and their subcontractors to inspect the chain of custody of the drugs delivered to participating CAP physicians. These commenters also requested that CMS establish and disseminate information about the procedure that participating CAP physicians should follow to report a suspected delivery of counterfeit drugs, and suggested that a web-based quality reporting system be available on various aspects of the approved CAP vendor's performance. These commenters also wanted clarification that one substantiated instance of purchase or distribution of a counterfeit drug by an approved CAP vendor will result in the automatic termination of the vendor's Part B supplier contract and the CAP contract.

Response: We continue to believe that existing Federal and State requirements, along with the specific requirements for approved CAP vendors outlined in the bidding and selection process, provide an adequate framework for protecting product integrity. Participating CAP Physicians should notify the approved CAP vendor immediately if there are any questions regarding the integrity of a CAP drug, and report any violations to the appropriate Federal and State authorities, as well as to the designated carrier's dispute resolution staff. In addition, the designated carrier will act promptly to investigate CAP quality complaints under the process outlined for dispute resolution as described in § 414.916.

As we gain experience with the CAP, we will assess whether additional steps are needed to ensure product quality. We are committed to ensuring that approved CAP vendors ship only high quality products and any reports of compromised quality will be addressed promptly.

(2) Subcontracting

In the July 6, 2005 interim final rule with comment (70 FR 39060, 39064, and 39065), we stated that a vendor could subcontract with another entity as long as that entity met all of our approved CAP vendor requirements, is in compliance with all applicable laws and regulations, has a demonstrable record of integrity regarding fraud and abuse and conflict of interest, and has adequate administrative arrangements in place to ensure effective operations. Information on specific requirements for subcontractors was provided in the July 6, 2005 interim final rule with comment and is a required part of the vendor's CAP application.

In § 414.914(f)(9), we also stated that it is the approved CAP vendor's responsibility to determine that subcontractors remain compliant with these standards. It was further noted that we intend that subcontractors or other entities associated with furnishing CAP drugs under an approved CAP vendor's contract maintain the same standards as the approved CAP vendor for the role that they play in supplying CAP drugs.

Comment: Many commenters expressed support that we intend to hold any subcontractors to the same standards as the approved CAP vendors. However, some commenters requested clarification on certain aspects of subcontracts or requested more stringent requirements. Two commenters requested that approved CAP vendors include in their subcontractor agreements a covenant binding on the subcontractor to comply with all rules applicable to approved CAP vendors, including those rules regarding product integrity and drug pedigree, and that HHS be a third party beneficiary to these agreements with the right to enforce any of the provisions relating to CAP compliance. One commenter wanted assurance that a contract between a large distributor and a specialty pharmacy would not be considered a conflict of interest.

Another commenter requested that we require full disclosure of a potential CAP vendor's corporate relationships and specifically prohibit potential CAP vendor subsidiaries from bidding against their parent company or other subsidiaries with the same parent company.

Response: We appreciate the commenters' interest in maintaining quality of the CAP by ensuring integrity in all aspects of the approved CAP vendor and subcontractor relationship. We believe that we have stated clearly our intention to hold all subcontractors to the same rigorous standards that we require of approved CAP vendors. We also believe that we have the necessary authority to review, enforce, and take any needed action to ensure that quality and integrity of the subcontractor relationship is maintained.

Because an approved CAP vendor is ultimately responsible for any activity of its subcontractor and risks termination of its CAP contract if quality or integrity are compromised, we believe that the approved CAP vendor will take adequate steps to ensure compliance with all requirements. Therefore, we will not require a binding covenant between approved CAP vendors and subcontractors, although we would expect that an approved CAP vendor may want to include this type of provision in its subcontracts for its own protection.

Contracts between a distributor and a specialty pharmacy are not automatically problematic. However, these arrangements would be subject to the same requirements as specified in the CAP statute and regulations that apply to all other subcontracting arrangements. Approved CAP vendors may wish to consult with legal counsel to determine whether there exists unique circumstances that could present a conflict of interest.

We also appreciate the commenters' concern about corporate relationships and the possibility of a potential CAP vendor's subsidiaries bidding against their parent company or other subsidiaries with the same parent company. However, because of the complexity of many corporate relationships, we believe that rejecting bids based on a test such as the commenter suggests could exclude some legitimate and qualified entities from participating in the CAP. We will not prohibit any qualified bidder from submitting a bid to be an approved CAP vendor, but we expect applicants to submit any relevant information, including information about their corporate relationships. We will review all this information as part of the application and bidding process described in this final rule with comment and the July 6, 2005 interim final rule with comment.

(3) Confidentiality of the Bids (Potential CAP Vendor Information)

In both the March 4, 2005 proposed rule (70 FR 10746) and the July 6, 2005 interim final rule with comment (70 FR 39065), we affirmed that all cost information will be confidential and not made available for public display, and that bid prices will be kept confidential in accordance with section 1927(b)(3)(D) of the Act.

We also stated that section 1847B(a)(1)(C) of the Act provides that, in implementing the CAP, the Secretary may waive provisions of the Federal Acquisition Regulation (FAR), ''other than provisions relating to the confidentiality of information.'' The confidentiality provisions of the FAR apply to the data submitted by bidders and potential CAP vendors under the CAP.

However, we noted that what is confidential for FAR purposes may not necessarily be protected under the provisions of the Freedom of Information Act (FOIA), and that if a FOIA request is received for pricing information, the request will be processed in accordance with 5 U.S.C section 552(b) and 45 CFR part 5, subpart F to determine whether any of the FOIA's exemptions to mandatory disclosure may apply to protect the information.

Comment: One commenter expressed concern that drug pricing information may be subject to disclosure under FOIA and suggested that it is protected from disclosure under FOIA exemption (b)(4). This commenter also suggested that drug pricing information provided under the CAP be treated the same as the drug pricing information provided for Hospital Outpatient Prospective Payment System (OPPS) and the Medicare Part D prescription drug benefit. Another commenter wanted assurance that all potential CAP vendor cost data will be protected as proprietary and will remain confidential and unidentifiable by manufacturer or wholesaler.

Response: We again affirm that, to the extent permitted by law, all cost information submitted during the bidding process and as part of the contract's price adjustment process will remain confidential and not made available, and that potential CAP vendor pricing information will be kept confidential. The FAR directly addresses the government's obligation to protect contractor information submitted in response to a solicitation for competitive bids. If a FOIA request is received seeking disclosure of a bidder's pricing data, that request would

be forwarded to the CMS FOIA officer for review in accordance with FOIA requirements. To the extent allowed by Federal law, we will assert applicable FOIA exemptions to protect confidential cost and pricing information. The FOIA exemptions are set forth in Department of Health & Human Services Freedom of Information regulations at 45 CFR part 5, subpart F.

(4) Approved CAP Vendor Requirements/Call Center Hours of Operation

In the July 6, 2005 interim final rule with comment (70 FR 39065), we stated that the approved CAP vendor would be required to—

- Maintain the operation of a grievance process so that participating CAP physician, beneficiary, and beneficiary caregiver complaints can be addressed;
- Provide a prompt response to any inquiry as outlined in the vendor application form;
- Maintain business hours on weekdays and weekends with staff available to provide customer assistance for the disabled, including the hearing impaired, and to Spanish speaking inquirers; and
- Provide toll-free emergency assistance when the call center is closed.

We also required that approved CAP vendors maintain a formal mechanism for responding to complaints from participating CAP physicians, beneficiaries, and their caregivers (if applicable) (70 FR 39065). Additionally, we stated that customer service is of primary importance and approved CAP vendors must demonstrate the ability to respond to inquiries on both weekdays and weekends (70 FR 39085).

Comment: We received no objections to any of the requirements. A commenter noted that although vendors are required to have procedures to resolve complaints and inquiries about CAP drug shipments, there were no clear standards for systems or procedures that approved CAP vendors must maintain. This commenter supported the establishment of a call center or other patient support center to answer patients' questions about billing, payment schedules, and other matters.

Response: We believe that customer service is of primary importance and that approved CAP vendors must demonstrate the ability to respond promptly and satisfactorily to inquiries from providers, beneficiaries, and caregivers. We believe that approved CAP vendors should have the flexibility to develop standards and systems that meet our requirements. However, we note that an approved CAP vendor will be required to respond to inquiries from a wide variety of sources, including beneficiaries and physician office staff, and that inquiries could come from a variety of time zones. Therefore, we are finalizing this policy and revising § 414.914 to reflect that an approved CAP vendor will be required to—

- Maintain the operation of a grievance process so that participating CAP physician, beneficiary, and beneficiary caregiver complaints can be addressed.
- Respond within 2 business days to any inquiry, or sooner if the inquiry is related to drug quality.
- Staff a toll-free line from 8:30 a.m. or earlier and until 5 p.m. or later for all time zones served in the continental United States by the approved CAP vendor on business days (Monday through Friday excluding Federal holidays) to provide customer assistance, and establish reasonable hours of operation for Hawaii, Alaska, Puerto Rico, and the other U.S. territories.
- Staff a toll-free emergency line for weekend and evening access when the call center is closed, and determine which hours on Saturdays and Sundays the call center will be staffed and which hours a toll-free emergency line will be activated.
- Include assistance for the disabled, the hearing impaired, and Spanish speaking inquirers in all customer service operations.

We also recommend that all approved CAP vendors have arrangements in place to obtain translation services in other languages if serving a sizable population of beneficiaries or caregivers whose language is other than English or Spanish and who do not have access to translator assistance.

When a beneficiary has a question about a coinsurance bill from an approved CAP vendor, the beneficiary is directed to contact the approved CAP vendor or his or her supplemental insurance provider (if applicable). If the beneficiary has no supplemental insurance, and believes he or she is not liable for the coinsurance bill, but is unable to resolve the situation on their own, the beneficiary may contact the designated carrier's customer service staff for assistance. The dispute resolution process is described in § 414.916(d) and in the July 6, 2005 interim final rule with comment (70 FR 39098).

(5) Prompt Pay Discounts

In the July 6, 2005 interim final rule with comment, we stated that prompt pay discounts should be disclosed by the approved CAP vendor and included in determining reasonable, net acquisition costs for purposes of section 1847B(c)(7) of the Act, and that we were interested in receiving comments about how these discounts are arranged and whether they are indeed different from other price concessions and discount arrangements.

Comment: Some commenters questioned the inclusion of prompt pay discounts in the determination of approved CAP vendors' reasonable net acquisition costs. They argued that so long as prompt pay discounts truly represent the time value of money and the fair market value of the distribution and financial services that are provided and are not passed on to providers, they should not be included in the approved CAP vendor's net acquisition costs. The commenters also raised issues with the treatment of prompt pay discounts under the ASP system.

Response: We disagree that prompt payment discounts should be excluded from the determination of an approved CAP vendor's reasonable, net acquisition costs. Section 1847B(c)(7) of the Act makes reference to an approved CAP vendor's ''reasonable, *net* acquisition costs''. The statute's use of the word ''net'' indicates these costs should reflect discounts the approved CAP vendor has received. Further, we believe it is appropriate that ''net acquisition costs'' be calculated in a manner consistent with the calculation of ASP. Prompt pay discounts are price concessions that must be included in a manufacturer's calculation of ASP. Please see section II.H.1 of this preamble, ASP Issues, for further discussion of prompt pay discounts under the ASP payment methodology.

(6) Bidding Process

In the July 6, 2005 interim final rule with comment, we stated that the composite bid ceiling will be determined on the basis of ASP prices in effect during the quarter in which the bids are generated, and that the single price for each drug (HCPCS code) will be initially determined on the basis of the median of the bids submitted during the second quarter of CY 2005 for that drug. We further stated that the price of each drug will then be updated to the mid-point of CY 2006 (five quarter increase) Producer Price Index (PPI) for prescription preparations.

Given the 6 month delay in implementation and the corresponding change in the bidding period, we will be making certain adjustments to the bidding process to account for more recent data. In general, we will retain the process described in the July 6, 2005

interim final rule with comment (§ 414.904). However, we will require bidders to base their bid on the October ASP file which accounts for the most recent ASP data available and can be found at *http://www.cms.hhs.gov/providers/drugs/asp.* As a result of the use of the updated drug pricing data and the delay in the implementation, we will no longer need to update the bid price by 5 quarters of PPI. Instead, we will update prices by 4 quarters of PPI. This allows the data to be trended forward from the period in which bidding is conducted (the fourth quarter of CY 2005) to the period in which the single prices will actually be in effect (second half of CY 2006). Specifically, the price of each CAP drug will be updated to the mid-point of the 2006 payment period on the basis of projecting the overall change in PPI prices for prescription preparations.

Bidding for potential CAP vendors will commence upon publication of this final rule with comment. Bidders will have at least 30 days to submit an application. Upon publication of the final rule, CAP bidding forms and additional information regarding bidding timelines, and other related material, can be found at *http://www.cms.hhs.gov/providers/drugs/compbid/bid_form_announ.asp.*

c. Operational Issues

In this section, we address drug product waste and returns, and when unused portions of single-use drugs may be billable to Medicare under the CAP. We address billing issues and timing of claims processing and payment. We address comments regarding coinsurance and collection of Advanced Beneficiary Notice forms (ABNs) and arrangements between approved CAP vendors and participating CAP physicians for services relating to the CAP.

We also address several CAP drug-ordering issues. We describe the resupply option and emergency use within the CAP. We clarify when a Medicare beneficiary's height and weight are needed for ordering a CAP drug. We also clarify the ''furnish as written'' option. Finally, we address patient confidentiality.

(1) Unused Drug Product (Waste and Returns)

In the July 6, 2005 interim final rule with comment (70 FR 39062), we responded to commenters asking for specific guidance on how to manage drug waste and returns as follows:

Although a variety of situations may create quantities of unused drugs at the place of administration, we believe the unused CAP drugs will come in the following 3 forms:

- An unopened vial (or vial package) as shipped by the approved CAP vendor.
- An opened vial (that may or may not be reconstituted or partly used).
- A drug that has been removed from a vial or package and is in a syringe, IV bag, or other device or container used for drug administration.

Unused quantities of a drug may increase the risk of waste, fraud and abuse, and attempts to use the excess drug may violate applicable pharmacy law or may compromise product integrity. We expect that approved CAP vendors will furnish drugs in a manner that will minimize unused drugs. We also expect that participating CAP physicians and approved CAP vendors will both make an effort to label, ship, and store CAP drugs in a manner that will allow the legally permissible reuse of an unopened and intact container of a CAP drug. Returns of unused products through a distribution system may be acceptable, but many States prohibit reusing drugs that have been dispensed by a pharmacy (For further information, see FDA Office of Regulatory Affairs (ORA) Compliance Policy Guides Manual Sec. 460.300, Return of Unused Prescription Drugs to Pharmacy Stock, CPG 7132.09). We are aware of situations when an approved CAP vendor may label a vendor-supplied outer container for prescriptions to keep the actual manufacturer's packaging intact and unlabelled. We further expect approved CAP vendors to offer and ship units of a drug that match the beneficiary's dosing requirements and HCPCS billing amount as closely as practical. In this way, a degree of waste will be prevented. Specific details, including how waste, returns, and their cost burden are handled, will depend on State law and regulation as well as the individual situations. Approved CAP vendors should establish policies on these issues (making sure that they comply with applicable laws and regulations) and make the policies available for physicians to review during the election period and through the term of the approved CAP vendor's participation in the CAP.

Approved CAP vendors will supply CAP drugs to participating CAP physicians' offices in unopened vials. However, in situations where a CAP drug is dosed by body weight or BSA, the amount of drug in vials may not match the Medicare patient's actual dose, and the approved CAP vendor will be forced to ship excess drug. In certain States, pharmacy law may prevent the use of excess CAP drug for another Medicare beneficiary if the order must be labeled as a prescription. The return process is guided by the following:

- Federal Law and guidelines (such as the FDA/ORA CPG 460.300), State law, Medicare requirements (such as the Claims Processing Manual), drug stability, and appropriate standards (such as United States Pharmacopoeia Chapter 797, Pharmaceutical Compounding—Sterile Preparations) will be used to determine how an extra drug product(s) may be used for subsequent dosing on the same beneficiary or for use on another beneficiary.
- If excess drug product remaining in a vial shipped by an approved CAP vendor must be returned, the approved CAP vendor is expected to accept excess CAP drugs for disposal and is expected to pay for shipping. The participating CAP physician is responsible for appropriately packing the drug. Consolidating shipping into larger and less frequent packages by the participating CAP physician would be encouraged. We do not intend for this process to be used as a vehicle for routine disposal of empty or nearly empty vials, disposal of any drug product not shipped by an approved CAP vendor, or disposal of drugs mixed in IV bags, syringes, associated needles and tubing, or other devices used in the administration of the drug product to a beneficiary.

The approved CAP vendor bills Medicare only for the amount of CAP drug administered to the Medicare beneficiary and the beneficiary's coinsurance amount will be calculated from the quantity of drug that is administered. Because the CAP statute authorizes us to pay the approved CAP vendor only upon administration of the CAP drug, any discarded drug (or drug that is considered waste) will not be eligible for payment.

We also stated that the CAP dispute resolution process will be available to resolve any associated disputes.

Comment: Most commenters objected to our payment policy for the unused portion of drugs. Most commenters perceived that the payment policy for the unused portion of a drug under the CAP was more restrictive than the payment policy for the unused portion of a drug under the ASP payment system. Many, but not all, commenters on this issue supported the general concept of payment for the unused portion of drugs contingent upon good faith efforts on the part of the participating CAP physician and approved CAP vendor to minimize unused drugs. However, some commenters indicated that payment to

the approved CAP vendor for the unused portion of CAP drugs should not be contingent on good faith efforts by the participating CAP physician, but only good faith efforts by the approved CAP vendor in furnishing the drug.

Response: Under the ASP payment system, physicians may bill the program for the unused portion of a drug remaining in an opened single-use vial if the physician made good faith efforts to minimize the unused portion of the drug in how he or she scheduled patients and how he or she ordered, accepted, stored, and used the drug. This policy does not apply to the unused portion of drugs from multiple use vials.

We expect that approved CAP vendors and participating CAP physicians will act and interact in a manner that will minimize unused drugs. Section 1847B(a)(3)(A)(iii) of the Act states that payment for CAP drugs is conditioned upon the administration of these drugs. We are clarifying that we consider the unused portion of a drug remaining in an opened single-use vial to be administered for the limited purpose of section 1847B(a)(3)(A)(iii)(II) of the Act, but only if the participating CAP physician has made good faith efforts to minimize the unused portion of the CAP drug in how he or she scheduled patients and how he or she ordered, accepted, stored, and used the drug, and only if the approved CAP vendor has made good faith efforts to minimize the unused portion of the drug in how it supplied the drug. This policy does not apply to the unused portion of drugs from multiple use vials.

We disagree with commenters who indicated that payment for the unused portion of drugs should not be contingent on good faith efforts by the participating CAP physician, but only on good faith efforts by the approved CAP vendor in supplying the drug. The program should not pay for the unused portion of a drug resulting from circumstances that were avoidable through good faith efforts. However, in response to these comments, we are including a new obligation in participating CAP physicians' CAP election agreement that requires the participating CAP physician to make good faith efforts to minimize the unused portion of CAP drugs in how he or she schedules patients and how he or she orders, accepts, stores, and uses the drugs. The requirement stated in the July 6, 2005 interim final rule with comment (70FR 39048) still applies, that when a participating CAP physician does not administer a CAP drug during the time frame specified on the prescription order, or administers a smaller amount of the drug than was originally ordered, the participating CAP physician must contact the approved CAP vendor to discuss what to do. If it is permissible under State law, and if the CAP drug is unopened and both the participating CAP physician and the approved CAP vendor are in agreement, then the participating CAP physician may retain the drug for administration to another Medicare beneficiary. However, before the drug could be administered to another Medicare beneficiary, the participating CAP physician would need to provide the approved CAP vendor with a new prescription order for the drug, and the approved CAP vendor would need to provide the participating CAP physician with a new beneficiary-specific prescription order number.

If the unused portion of the CAP drug is from a single-use vial, and all of the other conditions are met, the approved CAP vendor may bill for the unused portion of the CAP drug in the single-use vial. However, if the unused portion of the CAP drug is from a multi-use vial or an unopened vial, the participating CAP physician and approved CAP vendor must come to an arrangement on what to do with the unused CAP drug consistent with statute, the CAP regulations, and all applicable State and Federal laws and regulations. We note that unused CAP drugs are the property of the approved CAP vendor.

Comment: Some commenters asked for clarification of wastage, spillage or spoilage.

Response: Any drug or portion of a CAP drug that is not administered to a Medicare patient is considered wastage, spillage or spoilage. We note that if the other conditions described in the previous response are met, the unused portion of a CAP drug from a single-use vial is considered to have been administered for purposes of section 1847B(a)(3)(A)(iii)(II) of the Act, and, therefore, would not be considered wastage, spillage, or spoilage.

Comment: One commenter indicated that totally unopened or unused vials or packages ordered by the participating CAP physician should be purchased by the participating CAP physician for his or her own inventory.

Response: We expect participating CAP physicians will make good faith efforts to minimize unused CAP drugs. One of the goals of the CAP program is to allow physicians a choice between obtaining CAP drugs from approved CAP vendors selected in a competitive bidding process or acquiring and billing for Part B covered drugs under the ASP drug payment methodology. We do not believe that requiring participating CAP physicians to purchase totally unopened or unused vials or packages for their own inventory is consistent with this goal.

Comment: One commenter stated that many neurology practices that administer botox infusions split vials of the medication between two patients in cases where the patient does not need the full vial. The commenter indicated that the interim final rule with comment would prohibit this practice.

Response: We indicated in the interim final rule with comment that unused quantities of a drug may increase the risk of waste, fraud and abuse, and attempts to use the excess drug may violate pharmacy law and may compromise product integrity. However, we also indicated that specific details will depend on State law and regulation as well as the individual situations. Approved CAP vendors will establish policies on these issues (making sure that they comply with applicable laws and regulations) and make the policies available for physicians to review during the election period and through approved CAP vendor's participation in the CAP. Note also our policy regarding unused portions of a CAP drug from a single-use vial, which is described above.

(2) Timing of Approved CAP Vendor Billing/Payment of Claims

In the July 6, 2005 interim final rule with comment, we stated the participating CAP physician must file his or her drug administration claim within 14 days of administration (70 FR 39050 and 39095), and that the approved CAP vendor could not bill the beneficiary for drug product coinsurance until the claims matched and the approved CAP vendor received payment from the designated carrier (70 FR 39052 and 39097).

Comment: Potential vendors have proposed ways to shorten the time frame of the approved CAP vendor's payment window. One suggested that approved CAP vendors should be permitted to bill and be paid for drugs upon delivery to a participating CAP physician. Another suggested that the participating CAP physician be deemed to have ''purchased'' the drug if the participating CAP physician has not filed his or her claim within 14 days of delivery. These potential vendors are concerned about the viability of the CAP from a cash flow perspective.

Response: In most cases, assuming the participating CAP physician and the approved CAP vendor have promptly and properly submitted their claims, the approved CAP vendor should be paid by CMS within two to three weeks from the

date of drug administration. The anticipated sequence of events for the majority of CAP claims that are in compliance with local coverage determinations (LCDs) is described in the timeline in Diagram 1.

This timeline (diagram 1) is offered as an illustration of how the approved CAP vendor's drug claim and the participating CAP physician's administration claim would travel through the Medicare claims processing system using the month of October as an example. The claims depicted here are assumed to have passed ''front end edits'' and been considered ''clean claims.''

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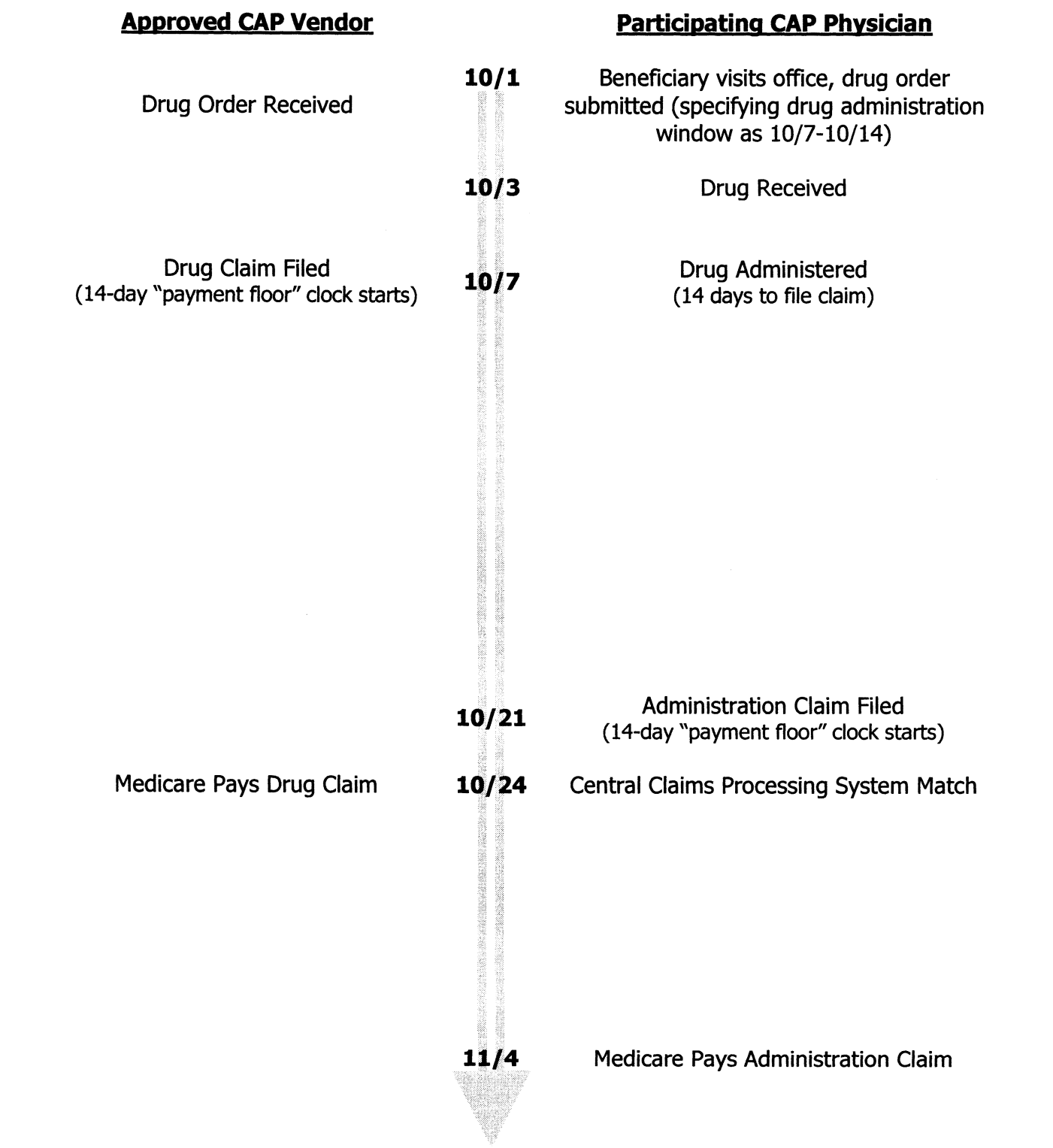
DIAGRAM 1



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In the July 6, 2005 interim final rule with comment, we asked the approved CAP vendor to submit its drug claim to the designated carrier no earlier than the first day of the anticipated week of administration as indicated on the drug order (70 FR 39040). After performing initial ''front end'' edits to validate the claim, the designated carrier will forward the approved CAP vendor's claim to the CMS central claims processing system. If there is not an immediate match between the approved CAP vendor's drug product claim and the participating CAP physician's drug administration claim in the CMS central claims system on the day the approved CAP vendor's claim is received, then the approved CAP vendor's claim goes into a recycling phase and will be reviewed for a match regularly thereafter. Section 1842(c)(3)(A) of the Act requires that no payment on an electronic claim shall be issued in less than 13 days. We add one day for mailroom and check handling and refer to this 14-day period as the ''payment floor.'' The payment floor clock starts on the day the approved CAP vendor's claim is received by the designated carrier as long as the claim passes all edits and is classified as a ''clean claim''.

In the July 6, 2005 interim final rule with comment, we stated that participating CAP physicians are required to file their claims for drug administration services within 14 days of the date of administration (70 FR 39050). Statistics obtained from Medicare claims filing data indicate that 75 percent of physician claims are filed within 14 days of the date of service, and that 95.6 percent of all Part B claims are considered clean when first filed. Within 3 days of receipt of a participating CAP physician's clean claim that has not been suspended for medical review, the CMS central claims processing system will generate a match between the participating CAP physician's claim and the approved CAP vendor's claim and permit payment of the approved drug vendor's drug product claim, provided the 14-day payment floor has been satisfied.

In the July 6, 2005 interim final rule with comment, we stated that drug administration claims will undergo electronic medical review for compliance with LCDs (70 FR 39038). Historically, approximately 5 percent of Part B drug claims are suspended for manual review, and approximately 7 percent of all claims (that is, not just those for Part B drugs) are denied. We expect that a small number of CAP drug claims will be reviewed for off-label use.

As for the 20 percent coinsurance portion of the bill, about 80 percent of Medicare beneficiaries have a supplemental insurance policy that covers the beneficiary's cost sharing obligation. Approved CAP vendors will know which beneficiaries have a supplemental policy because that information is required to be included on the prescription order. Approved CAP vendors will also be able to verify the beneficiary's supplemental coverage by contacting the supplemental insurer.

If the supplemental insurer has an arrangement with CMS as part of the automatic coordination of benefits process, the approved CAP vendor's claim will automatically cross over to the supplemental insurer after Medicare has paid its 80 percent share of the claim. In addition, under the mandatory Medigap crossover process, claims will be forwarded to the supplemental insurers for their use calculating their financial liability after Medicare if the approved CAP vendor properly coded the claim with the trading partner (for example, supplemental insurers) information. In both of these situations, after the supplemental insurer receives the claim it will issue applicable payment to the approved CAP vendor.

When an approved CAP vendor has supplied a CAP drug for administration to a beneficiary without supplemental insurance, the approved CAP vendor may bill the beneficiary upon receipt of Medicare's payment from the designated carrier or upon administration of the drug, if the approved CAP vendor has received notice of administration from the participating CAP physician. The approved CAP vendor may enter into a voluntary arrangement with a participating CAP physician to receive notification that the drug has been administered. The approved CAP vendor may also enter into a voluntary arrangement with the participating CAP physician to arrange for the collection of the beneficiary's coinsurance after the drug is administered, or to deliver information and notices on coninsurance assistance.

(3) Arrangements Between Approved CAP Vendors and Participating CAP Physicians for the Collection of Coinsurance and ABNs

In the July 6, 2005 interim final rule with comment, we stated that nothing in the CAP statute or regulations prohibited an approved CAP vendor and a participating CAP physician from entering into an agreement governing their arrangements for the provision of CAP drugs or other items or services (70 FR 39050). We added that parties to these agreements must ensure that the arrangements do not violate the physician self-referral (''Stark'') prohibition (section 1877 of the Act), the Federal anti-kickback statute (section 1128B(b) of the Act), or any other Federal or State law or regulation governing billing or claims submission.

Comment: Some commenters requested that we state explicitly that approved CAP vendors and participating CAP physicians are allowed to enter into these arrangements. They suggested that drug industry relationships commonly include supplier/physician arrangements. These commenters believed that approved CAP vendor/participating CAP physician arrangements will promote more participation in the CAP, stimulate greater cooperation between the parties, and generate fiscal efficiencies.

Physician and manufacturer commenters requested that we implement the CAP with safeguards that preserve the participating CAP physician's prescribing authority in the presence of these arrangements. They asked us to ensure that approved CAP vendors have no incentive and no regulatory pathway by which to restrict, limit, or change a participating CAP physician's access to specific drug and biological therapy.

Response: We are stating explicitly that nothing in the CAP statute or regulations prohibits approved CAP vendors and participating CAP physicians from entering into voluntary written arrangements that include—

- An arrangement between a participating CAP physician and an approved CAP vendor to notify the approved CAP vendor after the CAP drug has been administered to the beneficiary;
- An arrangement between a participating CAP physician and an approved CAP vendor to communicate with the beneficiary about coinsurance for CAP drugs on behalf of the approved CAP vendor;
- An arrangement between a participating CAP physician and an approved CAP vendor to issue an ABN on behalf of the approved CAP vendor;
- An arrangement between a participating CAP physician and an approved CAP vendor to collect applicable coinsurance and deductible on behalf of the approved CAP vendor from the beneficiary with no supplemental insurance coverage after the drug has been administered; and
- Any other appropriate and legal arrangement between a participating CAP physician and an approved CAP vendor. (We note that the provisions of § 414.914(h) also allow the participating CAP physician and the approved CAP vendor to enter into an arrangement for

the participating CAP physician to deliver notices related to the vendor's coinsurance assistance program.)

We will not dictate the breadth of use or the specific obligations contained in these arrangements, other than to note that they must comply with applicable law and to prohibit approved CAP vendors from coercing participating CAP physicians into entering any of these arrangements, as noted below. All written arrangements between approved CAP vendors and participating CAP physicians must comply with the requirements discussed below.

These arrangements should be carefully scrutinized by the parties to ensure that these arrangements are not disguised payments for referrals for items or services payable by a Federal health care program. These arrangements are subject to the physician self-referral (''Stark'') prohibition, the Federal anti-kickback statute or any other Federal or State law or regulation governing billing or claims submission. Arrangements should be at fair market value for actual services provided and should not take into account the volume or value of referrals. Percentage compensation arrangements or per item arrangements for billing and collection services between participating CAP physicians and approved CAP vendors would be highly suspect under the fraud and abuse laws.

Approved CAP vendors who enter into these arrangements with participating CAP physicians remain subject to liability for improper waivers of deductibles and coinsurance, including violations of the Federal anti-kickback statute and liability under section 1128A(a)(5) of the Act. Cost-sharing waivers are permitted under certain conditions for financially needy beneficiaries as specified in section 1128A(i)(6) of the Act. Parties should monitor these arrangements to ensure that waivers are made appropriately and create safeguards to ensure that these arrangements are not used by approved CAP vendors or participating CAP physicians as inappropriate marketing tools.

A participating CAP physician's decision to enter into an arrangement with an approved CAP vendor must be completely voluntary. An approved CAP vendor may not refuse to do business with a participating CAP physician because the participating CAP physician has declined to enter into an arrangement with the approved CAP vendor. Approved CAP vendors must accept all participating CAP physicians who choose to enroll with that approved CAP vendor.

Comment: Some commenters proposed that approved CAP vendors should have authority to obtain beneficiary credit card authorization before shipping drugs for them. One commenter suggested that Medicare withhold the approved CAP vendor's 20 percent coinsurance from the participating CAP physician's drug administration claim payment. The participating CAP physician would then collect both the administration coinsurance together with the drug product coinsurance from the beneficiary and/or the beneficiary's supplemental insurer. The approved CAP vendor would be paid the full amount.

Response: The CAP statute requires that we develop a process for the sharing of information between the participating CAP physician and the approved CAP vendor related to the payment of deductible and coinsurance (section 1847B(a)(3)(C) of the Act). In the July 6, 2005 interim final rule with comment, we interpreted this to mean beneficiary contact information, Medicare information, and third party insurance information (70 FR 39041). In the interim final rule with comment, we stated that we will not ask the participating CAP physician to collect the beneficiary's credit card information and share it with the approved CAP vendor because this information is not necessary to complete the drug ordering process, nor is it part of any supplemental insurance coverage that the beneficiary may have. We maintain that position in this final rule with comment. We do not ask the participating CAP physician to collect and forward credit card information to a third party supplier in any other Medicare setting. The beneficiary will have supplemental insurance approximately 80 percent of the time, rendering beneficiary payment information unnecessary in most cases.

We do not believe it is appropriate to require participating CAP physicians to secure drug coinsurance payment information from beneficiaries with no supplemental insurance, since provisions of section 1847B(a)(3)(A)(ii) of the Act make the collection of coinsurance the responsibility of the approved CAP vendor. However, as discussed previously, the participating CAP physician and the approved CAP vendor may enter into a voluntary arrangement, whereby the participating CAP physician, on the approved CAP vendor's behalf, would collect coinsurance from beneficiaries with no supplemental insurance coverage.

(4) Resupply Option/Definition of Emergency

As stated in the July 6, 2005 interim final rule with comment (70 FR 39037 and 39047), the four criteria that govern the resupply option are contained in section 1847B(a)(5) of the Act, which says that a participating CAP physician may acquire drugs under the CAP to resupply his or her private inventory if all of the following requirements are met:

- The drugs were required immediately.
- The participating CAP physician could not have anticipated the need for the drugs.
- The approved CAP vendor could not have delivered the drugs in a timely manner.
- The participating CAP physician administered the drugs in an emergency situation.

As we also stated in the July 6, 2005 interim final rule with comment, these criteria are set forth in the CAP statute, and, therefore, we do not have the authority to change them, or to allow that some of them be optional.

In the July 6, 2005 interim final rule with comment, we defined ''delivery in a timely manner'' for the resupply provisions of the CAP as the ability to meet emergency delivery standards for timely delivery as defined in § 414.902. We also defined ''emergency situation'' for the purposes of the resupply provisions of the CAP in § 414.902 as an unforeseen occurrence or situation determined by the participating CAP physician, in his or her clinical judgment, to require prompt action or attention for purposes of permitting the participating CAP physician to use a drug from his or her own stock, if the other requirements of § 414.906(e) are met.

In the July 6, 2005 interim final rule with comment, we stated that we anticipated that the local carrier would, at times, conduct a post-payment review of claims for emergency drug replacement in order to determine whether participating CAP physicians were complying with conditions for emergency drug replacement. The local carrier would use the emergency replacement modifier code to identify claims for emergency drug replacement for random post-payment review.

Comment: Numerous commenters expressed concern that the emergency resupply provisions were too restrictive and would have a negative impact on patient care. These commenters stated that, particularly for oncology treatment, health status changes are common, resulting in frequent changes in drug

dosage or medication(s). These commenters believe that the requirements regarding emergency resupply would result in delayed treatment for patients already ill, and increase the burden on the patient and their caregivers. The impact on people in rural areas who may live several hours from where they receive treatment was mentioned by many commenters, and it was suggested that the patient's driving distance be considered in the ability of a participating CAP physician to provide drugs out of office supply and be resupplied by the approved CAP vendor. One commenter also noted that acute and infectious disease patients could be at risk if there was any delay in treatment.

Some commenters expressed concern that participating CAP physicians who use the emergency resupply option might be subjected to unwarranted audits. Others expressed concern that frequent use of the emergency resupply option would result in adverse consequences for the participating CAP physician. There were also questions about the approved CAP vendor's ability to withhold shipment if the approved CAP vendor did not agree that an emergency existed or if they believe the drug that was used in the emergency situation would not be covered.

Response: As stated in the July 6, 2005 interim final rule with comment, we believe that the definition of emergency used in this situation should be one that enables the participating CAP physician to use his or her clinical judgment to determine when his or her patient needs immediate treatment. We have defined emergency for purposes of this provision as a situation determined by the participating CAP physician's clinical judgment to be an unforeseen situation that requires prompt action or attention. If the approved CAP vendor's emergency delivery timeframe would result in delivery of the drug after the time necessary to meet the patient's clinical need, it would be considered that the CAP drug could not have been delivered in a timely manner.

We are firm in our view that the determination of clinical need rests with the participating CAP physician and we leave it to the participating CAP physician to determine the scope of the clinical need. As previously stated, the participating CAP physician will assess whether all of the criteria are applicable and will document the patient's medical record accordingly. However, we do not believe that driving distance in itself should be a determining factor in the use of the emergency supply provision. Rather, the participating CAP physician should evaluate the entire clinical situation of the patient and make an appropriate determination based on all relevant information.

Approved CAP vendors do not have the authority to override a participating CAP physician's determination of what constitutes an emergency situation for purposes of the resupply provision. Policies regarding the shipment of CAP drugs are the same for the emergency resupply provision as they are for routine ordering and shipping of CAP drugs and for the ''furnish as written'' procedures. In all of these cases, the approved CAP vendor is required to deliver CAP drug(s) upon receipt of a prescription order, ensuring that the participating CAP physician's judgment about the appropriate treatment is the final determining factor in the decision-making process. The same principle applies to the emergency replacement process. If a participating CAP physician orders a CAP drug to resupply inventory on the basis of an emergency administration, the approved CAP vendor must ship it, unless the conditions of § 414.914(h) are met.

As stated in the July 6, 2005 interim final rule with comment, we anticipate that at times the local carrier would conduct a post payment review of emergency drug replacement in order to determine whether participating CAP physicians were complying with conditions for emergency drug replacement. We acknowledge that there may be some participating CAP physicians that may have legitimate reasons for more frequent use of the emergency resupply option. The post payment review process will also provide us with information on participating CAP physicians' use of the emergency resupply provision and help to distinguish between appropriate and inappropriate use of this provision. As we gain more experience with the CAP, we will assess whether the emergency resupply provision is working as intended, and whether further refinement is necessary.

(5) Order Form Information on Patient's Height and Weight

In the July 6, 2005 interim final rule with comment (70 FR 39095), we stated that the participating CAP physician would agree to provide specific information to the approved CAP vendor from whom he or she has elected to receive drugs information. The specific information required included the Medicare beneficiary's height and weight. We also stated that abbreviated information could be sent for repeat patient orders. We received comments regarding the patient's height and weight.

Comment: Some commenters stated that including the patient's height and weight on the CAP order form should not be required.

Response: It is possible for an approved CAP vendor to be a wholesaler distributor, a specialty pharmacy or a combination of both. State and Federal laws that govern specialty pharmacy operations may be different from those that govern wholesale distributor operations. For example, State laws, regulations, and recognized professional practice standards may require that specialty pharmacy services be provided by a qualified pharmacist. If the approved CAP vendor is a specialty pharmacy or distributor with an arrangement with a specialty pharmacy to supply drugs to a participating CAP physician, then information on patient height and weight may be required in order for a pharmacist to check a dispensed dose. If the approved CAP vendor operates solely as a drug wholesaler this information may not be necessary. To reflect the different requirements that may apply to different potential types of approved CAP vendors, we are amending § 414.908(a)(3)(v)(M) to specify that height and weight should be provided only if necessary.

(6) Furnish as Written

In the July 6, 2005 interim final rule with comment (70 FR 39043), we stated that we would allow the participating CAP physician to obtain a drug and bill Medicare under the ASP system using the ''furnish as written'' (FAW) option when medical necessity requires that a specific formulation of a drug be furnished to the patient, and that formulation is not provided by the approved CAP vendor. Documentation of the medical necessity must be maintained in the Medicare patient's medical record. The participating CAP physician would use a FAW modifier to identify that he or she was allowed to bill Medicare under the ASP system in this limited circumstance.

Comment: One commenter stated the examples given under the description of FAW were very narrow and would keep a participating CAP physician from using the FAW option proactively.

Response: If the approved CAP vendor does not carry a specific NDC that is medically necessary for a patient, the participating CAP physician may purchase the drug, bill for it and use the FAW modifier on the drug claim. In this situation, the local carrier will pay the participating CAP physician under the ASP payment system. We remind physicians that the FAW process

requires documentation of medical necessity.

Although the July 6, 2005 interim final rule with comment contained several examples of when the FAW process may be used, we did not intend to imply that these were exhaustive. The examples were meant to be illustrative, and were not meant to exclude other situations where FAW could legitimately be used in order to furnish a patient with the most appropriate therapy. Rather, we wished to indicate two points—(1) Participating CAP physicians who use FAW must appropriately document clinical judgment in support of the use of FAW; and (2) FAW is not intended to provide participating CAP physicians with an ''end run'' around their decision to participate in the CAP. The CAP is in no way intended to bar access to a medically necessary therapy. However, where medical necessity is served by the drug formulation supplied by the approved CAP vendor, coverage is available only if the participating CAP physician obtains the drug from the approved CAP vendor.

We again remind physicians that routine orders for CAP drugs should be placed at the HCPCS level. Specific products not on an approved CAP vendor's drug list that are medically necessary for the beneficiary may be obtained through the ASP system. Please note that the approved CAP vendor has the ability to request CMS approval to add new drugs to its CAP drug list. This process was discussed in the July 6, 2005 interim final rule with comment (70 FR 39075) and further described previously in this section.

(7) Patient Data Confidentiality

In the July 6, 2005 interim final rule with comment (70 FR 39065), we stated that approved CAP vendors would be required to comply with the HIPAA Administrative Simplification Rules, including the Privacy Rule.

Comment: One commenter requested that CMS explicitly prohibit approved CAP vendors from using, sharing, or selling patient information for any purpose other than that which is strictly related to fulfilling CAP orders. Another commenter wanted assurance that approved CAP vendor subcontractors would be subject to the same confidentiality requirements as the approved CAP vendor.

Response: We concur with the commenters that patient information must be protected from misuse, and believe that this requirement is adequately addressed by the requirement that approved CAP vendors comply with the HIPAA Privacy and Security rules. We also note that subcontractors are held to the same requirements and standards as the approved CAP vendor, including those pertaining to confidentiality.

d. Beneficiary Issues

In this section we discuss the policy permitting an approved CAP vendor to stop supplying drugs for a beneficiary who is not meeting their coinsurance obligations.

We also discuss the ABN process as it pertains to the CAP. Finally, we respond to comments about the financial liability of a Medicare/Medicaid dual eligible beneficiary who receives a CAP drug.

(1) Coinsurance

In the July 6, 2005 interim final rule with comment, we specified requirements at § 414.914(g) to include a provision requiring approved CAP vendors to provide information on sources of cost-sharing assistance available to beneficiaries on request (70 FR 39096). We noted that routine waiver of deductibles and coinsurance could violate the Federal anti-kickback statute, as well as, the civil prohibition on offering inducements to beneficiaries at section 1128A(a)(5) of the Act (70 FR 39050). However, cost-sharing waivers are permitted under certain conditions for beneficiaries who are experiencing financial hardship.

We also stated in the July 6, 2005 interim final rule with comment that we would not require an approved CAP vendor to continue to supply CAP drugs for beneficiaries who do not pay their deductible or coinsurance. Rather, we would allow the approved CAP vendor to refuse to make further shipments to the participating CAP physician for that beneficiary as long as the requirements of § 414.914(h) are met. In instances where a beneficiary failed to meet his or her obligation to pay coinsurance or deductible for a CAP drug, and the approved CAP vendor refused to continue providing the drug, we stated that we would permit the participating CAP physician to opt out of that drug category for the CAP.

Comment: Commenters from the community of potential CAP vendors expressed support for the approved CAP vendor's right to refuse to ship drugs for beneficiaries who do not meet their deductible and coinsurance obligations. They recommend removal of the requirement that the approved CAP vendor wait up to 60 days before discontinuing shipment of drugs on behalf of beneficiaries who do not meet their coinsurance obligations. The commenters offer that their exposure for additional uncollected coinsurance during the waiting period represents a risk so great that it renders participation in CAP untenable, and they should be permitted to collect coinsurance amounts on the day they ship the drugs.

Physicians and some drug manufacturers commented that the 45 to 60 day waiting period is too short, suggesting the period after the vendor's referral to a specific, bona fide charitable organization should be extended to permit the beneficiary sufficient time to apply for the aid, and the charitable organization time to process the request. A longer period was requested for cognitively impaired beneficiaries.

Response: Approved CAP vendors who become concerned about additional drug coinsurance exposure during the waiting period may make reasonable contact with the beneficiary for assurance that he or she is making timely and meaningful efforts to secure additional sources of funding. The additional 15-day waiting period after the specific, bona fide charitable organization referral represents a safety valve, and is not suggested as the starting point for the beneficiary's effort to secure alternative funding. The regulatory time periods set up a framework for an enforceable remedy. However, in light of the comments, and to reflect our policy change that an approved CAP vendor may make an arrangement with a participating CAP physician to collect coinsurance on its behalf, we are making modifications to § 414.914(h) to reflect that the 45-day period will begin on the date that the bill for coinsurance is delivered to the beneficiary whether it is mailed by the approved CAP vendor or delivered by the participating CAP physician on the behalf of the approved CAP vendor. We are also clarifying that the delivery of the coinsurance bill need not be subsequent to Medicare payment if the approved CAP vendor has received notice of drug administration from the participating CAP physician and the beneficiary lacks supplemental insurance. Because we believe the regulatory provision with this technical modification appropriately balances the interests of all involved, we are not going to change the length of the waiting period in § 414.904(h).

Comment: Some physician commenters have indicated that they waive coinsurance for indigent beneficiaries in some cases and expect that vendors should do likewise as a matter of routine.

Response: Approved CAP vendors and participating CAP physicians must conduct their business in compliance

with the requirements of sections 1128A(a)(5) and 1128A(i)(6) of the Act. In the July 6, 2005 interim final rule with comment (70 FR 39053) we stated that we were modifying the program requirements at § 414.914(g) to include a provision requiring approved CAP vendors to provide information on sources of cost-sharing assistance available to beneficiaries on request. It is important to note that routine waiver of deductibles and coinsurance can violate the Federal anti-kickback statute, as well as the civil prohibition on offering inducements to beneficiaries at section 1128A(a)(5) of the Act. However, cost-sharing waivers are permitted under certain conditions for beneficiaries who are experiencing financial hardship. The assistance offered by the approved CAP vendor must take the form of one of the following: A referral to a bona fide and independent charitable organization, implementation of a reasonable payment plan, or a full or partial waiver of the cost-sharing amount based on the individual financial need of the patient, provided that the waiver meets all of the requirements in § 1003.101(1) (Definition of ''Remuneration''). The availability of waivers may not be advertised or be made as part of a solicitation; however, approved CAP vendors may inform beneficiaries generally of the various categories of assistance noted in the preceding sentence. In no event may the approved CAP vendor include or make any statements or representations that promise or guarantee that beneficiaries will receive cost-sharing waivers. We will evaluate the procedures that applicant vendors propose to implement to make cost-sharing assistance referrals as part of the approved CAP vendor application review process.

Comment: Some physician commenters opposed the vendor's right to refuse further shipment because they believe it will fall to the physician to communicate to the beneficiary that his or her drugs are not being delivered, even though the decision to refuse shipment was the approved CAP vendor's.

Response: We understand the commenters' concern. However, when notifying the beneficiary of the approved CAP vendor's refusal to ship CAP drugs, the participating CAP physician need not justify the approved CAP vendor's decision. Instead, the participating CAP physician need only direct the beneficiary to the approved CAP vendor's grievance process. We believe it is the responsibility of the approved CAP vendor to notify the beneficiary about the conditions (specified in § 414.914(h)) under which the approved CAP vendor could permissibly cease delivery of CAP drugs for a beneficiary.

Comment: A few physician commenters expressed concern that an approved CAP vendor could use the refusal to ship for nonpayment of coinsurance as a way to influence the participating CAP physician's treatment plan, such as forcing the participating CAP physician to admit the beneficiary to a hospital.

Response: In order to preserve the flexibility of the participating CAP physician as required by the statute we have significantly limited the instances in which an approved CAP vendor can refuse to ship. However, we have a very specific process to provide the approved CAP vendor with some economic protection, and we will monitor the instances where an approved CAP vendor refuses to ship for nonpayment of coinsurance to ensure it is not being abused. The participating CAP physician may seek assistance from the CAP designated carrier in working out disputes where the participating CAP physician believes the approved CAP vendor is abusing the process under § 414.917.

Comment: One physician group commented that the regulation should be revised to require that the approved CAP vendor must provide information on cost sharing assistance to needy beneficiaries. The commenter stated that because the regulation at § 414.914(g)(3) and § 414.914(h)(3) state that the approved CAP vendor *may* inform beneficiaries that they generally make available categories of assistance such as referral to a bona fide charitable organization, implementation of a payment plan, or a full or partial waiver of the cost sharing amount that they were not required to do so.

Response: In the July 6, 2005 interim final rule with comment (70 FR 39086), we stated that the approved CAP vendor would be required on request, to provide information to beneficiaries on sources of coinsurance assistance. The regulations at § 414.914(g) state that the ''approved CAP vendor must provide assistance to beneficiaries experiencing financial difficulty in paying their cost sharing amounts * * *'' However, § 414.914(g)(3) and § 414.914(h)(3) state that approved CAP vendors may inform beneficiaries that they generally make cost sharing assistance available. It was our intention as reflected in the language in the preamble and § 414.914(g) and § 414.914(h)(3) to require approved CAP vendors to have a cost sharing assistance program available if the beneficiary expressed a need for one.

Section 14.914(g)(3) and § 414.914(h)(3) were intended to convey that approved CAP vendors may generally inform beneficiaries of the existence of this program rather than waiting for the beneficiary to request assistance. It was not our intention to convey that the approved CAP vendor had the option not to provide this assistance. In order to resolve any confusion we are revising § 414.914(g)(3) and § 414.914(h)(3) to reflect our original intent. The revision now reads, ''Approved CAP vendors *must* inform beneficiaries,'' that they generally make available the categories of assistance described in paragraphs § 414.914(g)(1), (g)(2), and (g)(3) of this section.''

Comment: One manufacturer commented that the vendor should be required to document ''reasonable collection efforts'' before being allowed to cut off a beneficiary.

Response: Because approximately 80 percent of beneficiaries have a Medicare supplemental policy that includes coverage for Part B cost sharing, their coinsurance and deductible payments should be made automatically in most cases by their supplemental insurer under the coordination of benefits process. Some beneficiaries without supplemental insurance may have difficulty making their coinsurance and deductible payments at times, and may seek assistance from the approved CAP vendor or some other third party. As we stated previously in this final rule and in the July 6, 2005 interim final rule with comment and consistent with the requirements of section 1128A(a)(5) of the Act and § 414.914(g) of the regulations, at the time of billing, the approved CAP vendor must inform the beneficiary generally of the types of cost-sharing assistance that may be available. If the beneficiary is unable to pay the coinsurance or deductible, he or she may request assistance from the approved CAP vendor as described above. The approved CAP vendor has an obligation to provide the information requested, and to take one of the actions specified in § 414.914(g). However, if the beneficiary has not requested financial assistance and if after a period of 45 days from delivery date of the approved CAP vendor's bill to the beneficiary whether by the approved CAP vendor or by the participating CAP physician on the behalf of the approved CAP vendor, the beneficiary's coinsurance obligation remains unpaid, the approved CAP vendor may refuse to make further shipments of drugs to the participating CAP physician for that

beneficiary. (We note that these provisions assume that the approved CAP vendor bills the beneficiary after payment is received from Medicare and his or her supplemental insurance provider (if applicable).)

If the beneficiary requests cost-sharing assistance and the approved CAP vendor refers the beneficiary to a bona fide independent charitable organization for assistance or offers a payment plan, the approved vendor must wait an additional 15 days from the date of delivery (which would be the postmark date when mailed and received date when hand delivered) of the approved CAP vendor's response to the beneficiary's request for cost-sharing assistance. If at the end of the 15-day time period, the approved CAP vendor has not received a cost-sharing payment (either from the charitable organization or from the beneficiary under the payment plan), the approved CAP vendor may refuse to ship additional drugs to the physician on behalf of that beneficiary. Further, if the approved CAP vendor implements a reasonable payment plan, it must continue to ship CAP drugs for the beneficiary, so long as the beneficiary remains in compliance with the payment plan.

Finally, if the approved CAP vendor waives the cost-sharing in accordance with section 1128A(i)(6)(A) of the Act and § 1003.101 and § 414.914(g)(3) of the regulations, it may not refuse to ship CAP drugs for the beneficiary. At this time, we believe that sufficient safeguards are built into the system to protect the beneficiary. Beneficiaries who believe that the approved CAP vendor is not adhering to these standards may use the vendor's grievance process. If that does not resolve the issue to their satisfaction they may request assistance from the designated carrier under the dispute resolution process. We will monitor the implementation of this provision to see whether a requirement that the approved CAP vendor document collection efforts should be implemented at a later date.

Comment: A beneficiary advocacy group requested that the approved CAP vendor be required to assess the beneficiary's financial condition and waive coinsurance for beneficiaries who meet a prescribed poverty test.

Response: Any beneficiary who is unable to meet his or her cost-sharing obligations is free to request assistance from the approved CAP vendor. We assume that if the approved CAP vendor administers its own plan rather than referring the beneficiary to a charitable organization for assistance, it will develop eligibility guidelines for the plan. We do not require any provider to waive coinsurance on a routine basis.

(2) Advance Beneficiary Notices (ABNs)

In the July 6, 2005 interim final rule with comment, we stated that the approved CAP vendor could issue an ABN to the beneficiary if the approved CAP vendor and the participating CAP physician did not agree about whether the drug administration service claim would be paid as a medically necessary service (70 FR 39058). We also stated that the approved CAP vendor may ask the participating CAP physician to deliver an ABN. If the participating CAP physician agrees to do so, he or she will describe both the administration of the drug and the drug product on the ABN, together with the estimated cost for each that the beneficiary must pay if he or she receives the drug and Medicare does not pay. We also noted that if the participating CAP physician declined to issue the ABN, then the approved CAP vendor could issue the ABN to the beneficiary before the drug was administered. In the July 6, 2005 interim final rule with comment, we used the phrase ''signed ABN'' where we meant to say ''enforceable ABN'' (70 FR 39039 and 39051). We wish to clarify this point because there are circumstances under which an ABN issued via telephone can be enforced. The requirements for delivery of ABNs can be found in the Medicare Claims Processing Manual, Pub. 100–4, Chapter 30, Section 40.3.4. These requirements may be accessed electronically at *http://cms.hhs.gov/manuals/104_claims/clm104c30.pdf.*

Comment: Some physicians commented that an obligation to collect an ABN on behalf of the approved CAP vendor represented an unwelcomed administrative burden. Others expressed concern that approved CAP vendors would overuse the ABN process, issuing ABNs even when the approved CAP vendor had no reasonable belief that the physician's drug administration claim or the vendor's claim for the drug would be denied. A commenter stated that it would be a logical anomaly for the approved CAP vendor to ask a participating CAP physician to collect an ABN in cases where the physician believes the drug administration services and, consequently, the drug product will be covered. The commenter believes this puts the participating CAP physician in an untenable situation and will serve to confuse the beneficiary unnecessarily.

Commenters from the community of potential vendors requested that we allow the approved CAP vendor to refuse to ship the CAP drug if the approved CAP vendor believes the applicable coverage policy prohibits payment and the participating CAP physician refuses to collect an ABN for the CAP drug on behalf of the vendor, suggesting that, in this case, the participating CAP physician should be allowed to use the furnish as written process. One commenter requested that we allow the approved CAP vendor to terminate CAP business with a participating CAP physician who refused to issue an ABN on behalf of the approved CAP vendor when the underlying claim was not paid.

Response: In response to the commenters' concerns, we reemphasize that the participating CAP physician's decision to issue an ABN on behalf of the approved CAP vendor is completely voluntary. An approved CAP vendor is always free to contact the beneficiary and issue an ABN on its own. Because the participating CAP physician's decision to issue an ABN is voluntary, the approved CAP vendor may not penalize the participating CAP physician who refuses to do so by refusing to ship the drug or attempting in some other way to force the participating CAP physician to obtain it. We note that, approved CAP vendors will have a disincentive to abuse the ABN process. Should an approved CAP vendor issue an ABN that is not consistent with CMS requirements, and the claim for the drug is denied and appealed to an Administrative Law Judge (ALJ), the ALJ could review the case and determine that the use of the ABN was inappropriate or invalid, thereby shifting liability to the approved CAP vendor. In addition, if an approved CAP vendor frequently seeks ABNs in cases where the participating CAP physician's local carrier routinely determines a particular drug to be covered, the approved CAP vendor may not be seen as a good business partner by the participating CAP physician and could lose his or her business at the next CAP election period. After careful consideration of the comments we have received, and balancing all the policy implications we have decided to maintain the policy with respect to ABNs set forth in the July 6, 2005 interim final rule with comment.

(3) Dual Eligibles

In the July 6, 2005 interim final rule with comment, we addressed the situation of beneficiaries who are dually eligible for the Medicare and Medicaid programs. We stated that Medicaid coinsurance payments would vary by State and that we had no authority to change the coinsurance amount based

on who was responsible for payment of the coinsurance (70 FR 39054).

Comment: Several commenters requested that we specifically state that dual eligible, Medicare/Medicaid beneficiaries may not be held responsible for more coinsurance than what the Medicaid State Agency pays. They have asked us to make clear that approved CAP vendors may not balance bill the beneficiary for that portion of the 20 percent Medicare coinsurance that is above the given State's Medicaid upper payment limit.

Response: State Medicaid programs can limit coinsurance payments to the extent that any payment for a covered Medicaid benefit, when combined with Medicare payments, equals the amount of reimbursement payable under the Medicaid program. A State Medicaid program may deem an approved CAP vendor to be paid in full even if it has received either no coinsurance payment or a reduced payment from the State. Dual eligible beneficiaries have no liability for a covered Medicaid benefit beyond the State's payment amount as set forth in section 1902(n)(2) of the Act.

e. Physician Election Issues and Education

In the July, 6, 2005 interim final rule with comment (70 FR 39079), we stated that section 1847B(a)(1)(A) of the Act specifies that each physician be given the opportunity annually to elect to participate in the CAP. Physicians who do not elect to participate in the CAP would continue to buy the drugs they provide to beneficiaries ''incident to'' their service and bill the Medicare program for them under section 1847A of the Act, the ASP system. Section 1847B(a)(5)(A) of the Act requires that we develop a process that physicians who wish to participate in the CAP may use to select an approved CAP vendor. This election is to occur on an annual basis. The statute requires that we coordinate this process with the Medicare Participating Physician Process described in section 1842(h) of the Act. Additionally, we stated that physicians who elect to participate in the CAP would be required to complete a CAP election agreement and would agree to the participating CAP physician requirements as established in the July 6, 2005 interim final rule with comment (70 FR 39079 through 39083).

In the July 6, 2005 interim final rule with comment, we also stated that the participating CAP physician election process would operate from October 1 to November 15 of each calendar year. In the September 6, 2005 interim final rule with comment interpretation and correction notice (70 FR 52930), we announced a delay in CAP implementation to approximately July 1, 2006. We anticipate that the bidding for the initial round of CAP will commence upon the publication of this rule. Thus, for this first CAP year the participating CAP physician election process will occur for approximately 6 weeks in early to mid-spring. Exact dates and election procedures will be announced on our web site. Later in 2006, we will conduct the annual participating CAP physician election for CY 2007. The election period for 2007 will occur from October 1, 2006 to November 15, 2006, with subsequent annual participating CAP physician election periods running from October 1 to November 15 of each calendar year thereafter.

In the July 6, 2005 interim final rule with comment, we stated that participating CAP physicians who wish to continue their participation in the CAP into subsequent years would do so by executing an abbreviated agreement, which would, if applicable, indicate a preference to change approved CAP vendors or, if applicable, CAP drug category. We also described specific instances in which participating CAP physicians will be permitted to select another approved CAP vendor or leave the CAP mid-year. These instances are when the selected approved CAP vendor ceases to participate in the CAP because its contract is terminated or suspended or if the participating CAP physician leaves the group practice that had selected the given approved CAP vendor or relocates to another competitive area (if multiple CAP competitive areas are implemented). Additionally, physicians newly enrolled in Medicare have 90 days from the date of enrollment to elect to participate in the CAP. The election process was summarized in the July 6, 2005 interim final rule with comment (70 FR 39083).

We also stated that when a physician bills as a member of a group using the group's Provider Identification Number (PIN), he or she must follow the group's election to participate or not to participate in the CAP. Thus, members of a group practice would elect to participate in the CAP as a group when billing under the group PIN. We also stated that if a group practice physician maintains a separate solo practice, he or she could make a separate determination of whether to participate in the CAP for the solo practice if using his or her individual PIN for the solo practice.

(1) Group vs. Individual Participation in CAP

We received several comments on the CAP participation of physicians who are in a group practice.

Comment: Several commenters suggest that when a physician is part of a group practice that the choice to elect the CAP should be made by the individual physician or by the physician specialty. Commenters sought clarification on the ability of physicians to be able to make their own, independent decisions related to the CAP so as not to affect the continuity of the group practices. One commenter specifically sought clarification on whether a physician within a group practice could opt out of CAP while his partners within the group opted in. The commenter believed that the language allows one physician within a group to continue with the ''buy and bill'' method while the others within the group opt to elect the CAP as long as the physician bills all of his or her professional services rendered to group patients under his or her own individual PIN.

Response: In the July 6, 2005 interim final rule with comment (70 FR 39082), we stated that we were required to coordinate the selection of the approved CAP vendor with agreements entered into under section 1842(h) of the Act (agreements to become a Medicare participating physician). The Medicare participating physician enrollment process coordinates the Medicare payment for the health care services delivered to a Medicare beneficiary. When payments for services are made to a health care provider, they are made based on the PIN. In order for a physician to ''buy and bill'' separately from the group he or she must not have reassigned his or her benefits to the group. By reassigning his or her benefits to the group practice, the physician will be billing Medicare using the group's PIN. Thus, the group will make the choice about whether to participate in the CAP.

Comment: Another commenter sought clarification on whether a non-participating physician who joined the CAP will be able to accept assignment for CAP drug administration.

Response: When a Medicare physician is a non-participating physician, he or she may still accept assignment on a case-by-case basis for his or her services. However, he or she must agree to accept assignment for all Medicare Part B drug payment as specified in section 1842(o)(3)(A) of the Act. If the non-participating physician elects to participate in the CAP he or

she will no longer be billing Medicare for the Part B drugs that he or she obtains through CAP, but he or she will still be able to bill Medicare for the administration of those drugs. Thus, if a non-participating physician elects to participate in the CAP, he or she must agree to accept assignment for drug administration for all CAP drugs to allow for the Medicare beneficiary's and approved CAP vendor's appeal rights.

(2) Practitioners in CAP-Clarification

In the July, 6, 2005 interim final rule with comment, we stated that physicians would have a choice to participate in the CAP or continue to buy the drugs they provide to beneficiaries ''incident to'' their service and bill the Medicare program for them under the ASP system as specified in section 1847A of the Act. We would like to clarify that for the purposes of the CAP, a physician includes all practitioners that meet the definition of a ''physician'' in section 1861(r) of the Act.

(3) Physician Choice of Approved CAP Vendor

Comment: One commenter believes that approved CAP vendors will be entirely dependent on physicians for various actions including—filing claims, appealing a denial, obtaining beneficiary information, and, where necessary, obtaining an ABN. The commenter asserts that approved CAP vendors should be allowed the right to decline to work with a participating CAP physician who has—

- Previously failed to pay for drugs on a timely basis.
- Materially breached his or her contractual obligations to the approved CAP vendor or his or her CAP election agreement with CMS.
- Acted in a manner that obstructs the purpose or intent of the CAP, or otherwise hinders its effectiveness.
- Otherwise acted in bad faith.

The commenter is concerned that as long as a participating CAP physician is not currently suspended, the participating CAP physician may select any approved CAP vendor he or she wishes, including an approved CAP vendor that might have generated a suspension request for that participating CAP physician. The commenter further asserts that because of the critical reliance of approved CAP vendors on participating CAP physician's compliance with CAP requirements that in the event of the participating CAP physician's noncompliance the approved CAP vendors should have the right not to work with a participating CAP physician if it has a reasonable basis for concern. The commenter also believes it is important for the approved CAP vendor to have some recourse when it will potentially be selling drug products to the physician, and, thus, potentially be owed significant amounts by a physician in certain situations.

Response: The commenter's reference to a vendor ''selling'' drugs to a physician appears to be expressing concern about an approved CAP vendor's relationship with a participating CAP physician outside the scope of the CAP. These relationships are beyond the scope of this rule. Currently, physicians purchase the drugs they administer to their Medicare beneficiary patients and are reimbursed for those drugs through the ASP payment system. The CAP is an alternative way for physicians to obtain drugs. In the CAP, the participating CAP physician does not purchase CAP drugs, but rather orders them. Because participating CAP physicians will not own the CAP drugs they order from the approved CAP vendor, the approved CAP vendor will not be ''selling'' the drug to the participating CAP physician. Instead, the approved CAP vendor will ship CAP drugs to the participating CAP physician and bill Medicare for them upon administration. In addition, as we have stated in this final rule with comment and the July 6, 2005 interim final rule with comment, an approved CAP vendor must accept any participating CAP physician who selects it. However, in developing the CAP, we recognized that the approved CAP vendor, as the owner of the CAP drugs, would have significant financial risk. We developed a dispute resolution process to assist the approved CAP vendor if there were occurrences of participating CAP physician noncompliance within the program. In the July 6, 2005 interim final rule with comment (70 FR 39054), we detailed the dispute resolution process for addressing participating CAP physician's non-compliance with CAP obligations. We believe the dispute resolution process is the appropriate forum for addressing these concerns.

(4) Participating CAP Physician Mid Year Opt-Out

In this section, we discuss the comments received concerning the ability of a participating CAP physician to opt-out of the CAP prior to the end of the year and our responses to those comments.

Comment: We received a number of comments requesting that participating CAP physicians have the ability to opt-out of CAP for any approved CAP vendor issues, including quality and delivery issues.

Response: We understand the commenters' concerns. We believe that we have provided for a sound method to ensure the quality of the CAP and to resolve these issues. As discussed in the July 6, 2005 interim final rule with comment (70 FR 39058), we established financial and quality standards to ensure that we choose reputable and experienced vendors to participate in the CAP.

Participating CAP physicians will have the option of changing approved CAP vendors or opting out of the CAP program on an annual basis. We also provided the circumstances, as specified in § 414.908(a)(2), under which a participating CAP physician may choose a different approved CAP vendor mid-year or opt-out of the CAP. These circumstances are: (1) If the selected approved CAP vendor ceases to participate in the CAP; (2) if the participating CAP physician leaves the group practice that had selected the approved CAP vendor; (3) if the participating CAP physician relocates to another competitive acquisition area (once multiple CAP competitive areas are developed); or, (4) for other exigent circumstances defined by CMS. We identified a separate exigent circumstance relating to instances in which an approved CAP vendor declines to ship CAP drugs (when the conditions of § 414.914(h) are met) in § 414.908(a)(5). We note that in all these cases, while there is only one drug category for CAP, the participating CAP physician would be allowed to opt-out of the CAP altogether.

In the July 6, 2005 interim final rule with comment, we also discussed how the participating CAP physician would use the approved CAP vendor's grievance process for drug quality and service issues and turn to the designated carrier for assistance in developing solutions (70 FR 39057). If a participating CAP physician is dissatisfied with the drug quality or drug delivery performance of an approved CAP vendor, we expect the participating CAP physician to attempt to resolve the issue with the approved CAP vendor informally, and then to use the approved CAP vendor's grievance procedure. The next step is to ask for the designated carrier's assistance in developing a solution with cooperation from both parties. The designated carrier will act promptly to investigate quality and service issues. If these are not resolved, the designated carrier may recommend to CMS the suspension or termination of the approved CAP vendor's contract. We will act on that

recommendation after gathering any necessary, or additional information from the participating CAP physician and approved CAP vendor. If the approved CAP vendor is suspended from the program, that vendor will be unable to participate in the CAP for the remainder of that year. The ultimate sanction for service and quality issues is termination of the approved CAP vendor's 3-year contract upon exhaustion of the reconsideration process as specified in § 414.917. If the approved CAP vendor contract is suspended or terminated, the participating CAP physician would be able to choose another approved CAP vendor or leave the CAP altogether.

(5) Participating CAP Physician Opt-Out for Non-Payment of Coinsurance

In the July 6, 2005 interim final rule with comment (70 FR 39053), we stated that in instances where a beneficiary has failed to meet his or her obligation to pay the coinsurance or the deductible for a drug, the conditions of § 414.914(h) were met, and the approved CAP vendor has refused to continue shipping CAP drugs to the participating CAP physician for the beneficiary, we will permit the participating CAP physician to opt-out of that drug category for the CAP. We noted that for the initial implementation of the CAP, there is only one CAP drug category. Thus, a participating CAP physician exercising this option will be opting out of the entire CAP program until the next opportunity to elect to participate.

We are making a technical change to § 414.908(a)(5) to state that if the approved CAP vendor refuses to ship to the participating CAP physician because the conditions of § 414.914(h) have been met; the participating CAP physician can withdraw from the applicable CAP drug category for the remainder of the year immediately upon notice to CMS and to the approved CAP vendor. We note again, that for the initial implementation of the CAP, there is only one CAP drug category. Thus, a participating CAP physician exercising this option will, in effect, be opting out of the entire CAP program until the next opportunity to elect to participate.

Comment: We received numerous comments on the exigent circumstance that allows a participating CAP physician to opt-out of CAP if an approved CAP vendor were to stop providing a drug to a Medicare beneficiary due to non-payment of the coinsurance to the approved CAP vendor. Commenters requested that we allow the participating CAP physician to opt-out of CAP for only that one Medicare beneficiary allowing the participating CAP physician to continue in CAP for the other Medicare beneficiaries.

Response: We do not believe that allowing a participating CAP physician to opt-out of CAP on a beneficiary-by-beneficiary basis is consistent with the CAP statute. When a physician elects to obtain drugs through the CAP that physician will no longer be able to bill Medicare for drugs under the ASP methodology that is available from the approved CAP vendor unless permitted under the ''furnish as written'' option. The approved CAP vendor will bill Medicare for the CAP drugs administered by the participating CAP physician. Therefore, if an approved CAP vendor has refused to ship the CAP drug as specified in § 415.914(h), we will permit the participating CAP physician to opt-out of CAP for that category. However, we note that for the initial implementation of CAP there is only one drug category.

(6) Physician Education

In the July 6, 2005 interim final rule with comment, we stated that we would instruct the Medicare carriers to use various communication channels at the local and national levels to disseminate information about the CAP and assist approved CAP vendors and participating CAP physicians in understanding the Medicare program's operations, policy, and billing and administration procedures regarding the CAP in conjunction with use (70 FR 39084). The Medicare carriers will be instructed to use data analyses in tailoring their outreach and educational efforts for potential vendors and physicians regarding identified areas of confusion about the CAP. Additionally, we specified that the Medicare carriers would be instructed to use mass media, as well as educational and outreach products, services, forums, and partnerships in an effort to disseminate information about, and provide assistance regarding, the CAP to potential vendors and healthcare practitioner communities. We stated that the goal of our outreach and education would be to ensure that those who provide services to Medicare beneficiaries receive the information they need to understand the Medicare program so that they can administer it and bill it correctly.

Comment: There were comments requesting assistance and education for the CAP. One commenter was concerned with the availability of assistance and education to the participating CAP physician discussed in the July 6, 2005 interim final rule with comment. The commenter asserted that we have not elaborated on how physicians would be able to obtain education and assistance on CAP throughout the year. The commenter believed that physicians will have questions related to the CAP processes or other technical aspects not clear at the beginning of the program. The commenter also believed that we might make changes during the course of the year once the program is implemented and improvements are instituted. The commenter encouraged us to anticipate the need for on-going, real-time assistance to the participating CAP physician utilizing the CAP, particularly in the first year and implement a proactive education strategy. Another commenter requested that given the short time frame allowed for the CAP election, we ensure that physicians are properly educated and informed about CAP before they make an election. They suggested that we require approved CAP vendors to provide participating CAP physicians with a disclosure form and to certify that they have accurately disclosed all program features including administrative requirements, technical/software requirements, penalties, restrictions on delivery and transporting of drugs.

Response: The commenter is correct to note that there will be changes in the CAP during the course of the year. As we previously discussed, approved CAP vendors will have the opportunity to request approval to change their drug lists in several ways. Physicians should be aware of this before electing to participate in the CAP, but CMS and approved CAP vendors will inform participating CAP physicians of these and other changes on a timely basis, as described in a previous section of this preamble.

In the July 6, 2005 interim final rule with comment, we stated that we would post on our Web site, the approved CAP vendors we have selected for the CAP, their categories of drugs (and specific NDCs), and the geographic areas within which they would operate (70 FR 39081). (See *http://www.cms.hhs.gov/providers/drugs/compbid/*). We stated that we would publicize the participating CAP physician election information on our Web site, listservs, Medicare fee-for-service contractors' Web sites, and newsletters. We stated our intention to coordinate with physician specialty organizations to inform their members that the participating CAP physician election information is available. We also stated that we would provide a CAP fact sheet so that the carriers can disseminate it to their physicians and that there would be an education campaign to inform

physicians about the CAP Web site and the election process. We described our plan to make available, the participating CAP physician election agreement forms with instruction on how to download, complete, and sign them and return them to the local carrier. The local carrier will note the physician's decision to participate in the CAP, the approved CAP vendor and the selected categories of drugs (when multiple categories of drugs become available). The local carrier will forward information from the participating CAP physician election agreement to the CAP designated carrier. The designated carrier will compile a master list of all participating CAP physicians' approved CAP vendor and drug category selections. In addition, the designated carrier will notify each approved CAP vendor of the participating CAP physicians who have elected to enroll with that approved CAP vendor.

Throughout the year we will continue to provide participating CAP physician assistance through the participating CAP physician's local carrier and the designated carrier. Both the participating CAP physician's local carrier and the designated carrier will have toll free numbers for participating CAP physicians to use in requesting assistance.

f. Brief Summary of Comments We Are Not Addressing

In response to the July 6, 2005 interim final rule with comment, we received comments on a wide variety of issues related to the CAP. This final rule with comment addresses those issues that are most urgent to begin CAP implementation. Other issues raised in the comments will be fully considered and addressed at a later time.

Among the comments we are not addressing at this time are comments related to rural operational issues, the impact of CAP delivery times on satellite clinics, restrictions on transporting drugs, the 14 day participating CAP physician billing requirement, impact on clinical research, and licensure requirements for CAP pharmacies and distributors.

I. Private Contracts and Opt-Out Provision

Section 4507 of the BBA of 1997 amended section 1802 of the Act to permit certain physicians and practitioners to opt-out of Medicare if certain conditions were met, and to provide through private contracts services that would otherwise be covered by Medicare.

When a physician or practitioner fails to maintain the conditions necessary for opt-out and does not take good faith efforts to correct his or her failure to maintain opt-out, current regulations at § 405.435(b) specify the consequences to that physician or practitioner for the remainder of that physician's or practitioner's 2-year opt-out period. However, § 405.435(b) describes a situation where the Medicare carrier notifies the physician or practitioner that he or she is violating the regulations and the statute. As explained in the August 8, 2005 proposed rule, the current regulations do not address the consequences to physicians and practitioners in situations when a condition resulting in failure to maintain opt-out occurs during the 2-year opt-out period, but a Medicare carrier does not discover or give notice of a physician's or practitioner's failure to maintain opt-out during the 2-year opt-out period. We proposed to amend § 405.435 in order to clarify that the consequences specified in § 405.435(b) for the failure on the part of a physician or practitioner to maintain opt-out will apply regardless of whether or when a carrier notifies a physician or practitioner of the failure to maintain opt-out. We also proposed to add a new paragraph (d) to clarify that in situations where a violation of § 405.435(a) is not discovered by the carrier during the 2-year opt-out period when the violation actually occurred, then the requirements of § 405.435(b)(1) through (b)(8) would be applicable from the date that the first violation of § 405.435(a) occurred until the end of the opt-out period during which the violation occurred (unless the physician or practitioner takes good faith efforts to restore opt-out conditions, for example, by refunding the amounts in excess of the charge limits to beneficiaries with whom he or she did not sign a private contract). These good faith efforts must be made within 45 days of any notice by the carrier that the physician or practitioner has failed to maintain opt-out (where the carrier discovers the failure after the 2-year opt-out period has expired), or within 45 days after the physician or practitioner has discovered the failure to maintain opt-out, whichever is earlier.

Comment: One commenter stated that having physicians suffer regulatory consequences for failure to maintain opt-out status, even when they are not notified of their status, would be unfair and discouraging. They recommended that Medicare carriers be required to notify physicians of their opt-out status 60 days before any actions are taken against them.

Response: The revision to § 405.435 does not instruct Medicare carriers to take action against physicians without sufficient notice to the physician. In situations where a physician or practitioner fails to maintain opt-out and the carrier discovers that violation either during the physician's or practitioner's opt-out period or after it expires, carriers will notify the physician or practitioner of the violation and the physician or practitioner will have 45 days from the date of the carrier's notice to correct that violation. Similarly, in the situation where the physician or practitioner discovers that he or she has failed to maintain opt-out, the physician or practitioner will be on notice that unless he or she takes corrective action within 45 days the provisions of § 405.435(b)(1)–(b)(8) are applicable. We do not agree with the commenter's suggestion that the 45-day period for taking corrective action should begin in all cases until the carrier sends a notice, that is, including situations in which the physician or practitioner discovers the failure to maintain opt-out. If physicians and practitioners were permitted to intentionally violate their opt-out responsibilities, or ignore unintentional violations that they discovered subsequently, until the carrier notifies the physician or practitioner of the violation, harm to both beneficiaries and the program could result. For example, beneficiaries could enter into private contracts that do not meet the notice requirements of § 405.415 or the Medicare program could make mistaken payments due to the physician or practitioner billing Medicare in violation of § 405.425. In order to minimize these harms when a physician or practitioner discovers a failure to maintain opt-out, we believe the 45-day period should begin on the date the failure to maintain opt-out is discovered, not at some later date when a carrier discovers the failure and gives notice.

Comment: One commenter stated that the proposed rule would establish regulations that address situations where a physician or practitioner that has opted out of the Medicare program fails to maintain the requirements of their status. In particular, the proposed regulatory language would provide physicians or practitioners that have opted out of the Medicare program 45 days to correct the violation. The commenter believes these regulations are reasonable as proposed. However, the commenter urges the agency to establish standardized language for the violation notice and clear guidelines for carriers to execute timely notice of opt-out violation.

Response: The CMS Internet-Only Manual (Publication 100–2, chapter 15, section 40.12) currently provides Medicare's carriers with standardized guidelines regarding the notice to physicians and practitioners, and the actions to take, in cases of failure to maintain opt out status.

We are finalizing our proposed changes to § 405.435 (b) and adding new paragraph (d) as proposed.

J. Multiple Procedure Payment Reduction for Diagnostic Imaging

As explained in the August 8, 2005 proposed rule (70 FR 45849), diagnostic imaging procedures are priced in the following three ways:

- The professional component (PC) represents the physician work, that is, the interpretation.
- The technical component (TC) represents PE, that is, clinical staff, supplies, and equipment.
- The global service represents both PC and TC.

Under the resource-based PE methodology, specific PE inputs of clinical labor, supplies, and equipment are used to calculate PE RVUs for each individual service. We do not believe these same inputs are needed to perform subsequent procedures. When multiple images are taken in a single session, most of the clinical labor activities and most supplies are not performed or furnished twice. In addition, equipment time and indirect costs are allocated based on clinical labor time; therefore, these inputs should be reduced accordingly. Excluding these PE inputs, which we believe are duplicative, supports a 50 percent reduction in the payment for the TC of subsequent procedures. A reduction of 50 percent is also currently used in the multiple procedure payment reduction for surgery, which has been a longstanding policy.

Therefore, we proposed extending the multiple procedure payment reduction to the TC of specific procedures listed in Table 29 of the August 8, 2005 proposed rule (70 FR 45850). Table 29 identified 11 families of imaging procedures by imaging modality (ultrasound, CT and computed tomographic angiography (CTA), MRI and magnetic resonance angiography (MRA)), and contiguous body area (for example, CT and CTA of Chest/Thorax/Abdomen/Pelvis). We proposed applying the reduction only to procedures involving contiguous body areas within a family of codes, not across families, and to those multiple procedures that were provided in one session. We also proposed only to apply the multiple procedure payment reduction to the TC of certain procedures because, while we believe there may be some reduction in physician work associated with the performance of multiple diagnostic imaging procedures on contiguous body areas, we have no specific plans to extend the proposal to the PC. In addition, since the global service payment equals the combined PC and TC components, when the global service code is billed for these procedures, the TC would be reduced to the same as above, but the PC would be paid in full. We proposed making full payment for the TC of the highest priced procedure and payment at 50 percent of the TC for each additional procedure.

Comment: Several commenters supported our proposal, and described it as appropriate, reasonable, justified, rational, and consistent with the private sector. One commenter suggested extending the proposal to the professional component. Two other commenters stated that it should not be applied to the professional component. One commenter suggested applying the reduction to noncontiguous body areas imaged using the same modality. Another commenter indicated an understanding of the rationale for the proposal but did not want it extended to traditional radiographs.

Response: We appreciate the commenters' support. We currently have no plans to extend our proposal to incorporate the commenters' suggestions (that is, to include noncontiguous body areas, other radiologic examinations, or the professional component of imaging services). We are not certain whether and to what degree a multiple procedure payment reduction policy would be appropriate in these types of situations.

Comment: Several commenters opposed our proposal on the basis that diagnostic imaging is not comparable to surgery. For example, they noted that diagnostic imaging is not paid as part of a global package of services; its pre and post activities and resources are typically not as extensive as those required for surgery, and so should comprise a much smaller portion of the payment than for surgery; and it is highly capital intensive compared to surgery. One commenter stated that nuclear medicine procedures were inappropriately discounted and should not serve as precedent for discounting diagnostic imaging procedures.

Response: We agree that diagnostic imaging procedures are not comparable to surgical procedures and did not base the development of the multiple imaging procedure payment reduction policy on specific comparisons with the reductions applicable to multiple surgical procedures. Instead, with findings from the MedPAC recommendation about a multiple imaging procedure reduction, detailed information regarding current imaging reduction payment policies in the private insurance industry, and our analysis of PE data, we believe that the rationale for the proposed reduction is sound. The 50 percent reduction was specifically founded upon well-established and professionally accepted data we examined from the PEAC, as described below, and was not based simply on the fact that a 50 percent reduction is applied to multiple surgical procedures. In addition, the reduction for six nuclear medicine procedures has been in effect for 11 years. During that time, we have received no evidence to indicate that it is not appropriate. Nevertheless, we did not base our multiple imaging procedure reduction policy on comparisons with nuclear medicine procedures.

Comment: Numerous commenters agreed that some clinical labor activities, supplies, and equipment are not duplicated for subsequent procedures. Other commenters indicated exactly the opposite (that is, that these items, including some portion of scanning time, are duplicated). In addition, some commenters indicated that where equipment adjustments are required between studies, clinical labor time could actually increase when multiple imaging procedures are performed on the same patient during a single session.

The majority of commenters agreed that there are some efficiencies when multiple procedures are performed but disagreed that all the activities we listed above are never duplicated. Therefore, they disagreed that the efficiencies achieved in subsequent procedures support a 50 percent reduction. Many commenters indicated that a 50 percent reduction is arbitrary and that we provided no supporting data. Several commenters suggested that the reduction should be somewhere between 5 and 25 percent. The ACR offered several suggestions on the relative level of reduction among families of procedures, for example, that the reduction for the procedures in family four should be less than for family two; and that the reduction for procedures in family seven should be less than for family two, but greater than for family four. However, they provided no specific percentages for the reductions in each family.

A few commenters recommended varying the percentage reduction by modality because efficiencies are not

uniform across all families of procedures. Two commenters indicated that the proposal was inconsistent with the mandate to make resource-based PE payments. Specific comments included the following:

- For ultrasound procedures, all clinical labor activities except for greeting the patient, are duplicated.
- For some CTs, repositioning the patient is necessary. Some CTs require multi-phasic contrast injections that are separately scanned.
- For CTs, MRIs and MRAs, the number of prior exams for review before the studies are performed has increased significantly.
- Some CTs, CTAs, MRIs, and MRAs require more images, slices or pulse sequences.
- For brain MRIs and neck MRAs, it is necessary to remove the patient; change from a head coil to a neurovascular coil; retune the coil; enter multiple new scan parameters; reposition the patient; and run a new set of pulse sequences. The patient often requests a break between procedures.

Several commenters recommended delaying implementation of the proposal for 1 year pending further study. Their reasons included: postponing until the PE inputs are fully implemented and clearly defined; deferring until the entire PFS methodology is reassessed; and delaying until MedPAC's other imaging study recommendations are implemented. Two commenters suggested that we phase-in the reduction. The ACR offered to work with CMS to reexamine the procedures subject to the reduction; reconfigure the families of procedures; and, determine appropriate reductions based on modality family.

Response: We indicated in the proposed rule that the following activities are not duplicated for subsequent procedures:

- Greeting the patient.
- Positioning and escorting the patient.
- Providing education and obtaining consent.
- Retrieving prior exams.
- Setting up the IV.
- Preparing and cleaning the room.

In addition, we consider supplies, with the exception of film, are not duplicated for subsequent procedures. Therefore, the 50 percent reduction for subsequent procedures is based on eliminating the time for the clinical labor activities noted above, plus supplies, with the exception of film. We do not assume any reduction in procedure (scanning) time or equipment for subsequent procedures. However, as noted in the proposed rule, equipment, time, and indirect costs are allocated based on clinical labor time; therefore, these inputs were reduced accordingly.

The 50 percent reduction was determined based on the examination of multiple pairs of procedure codes from the families representing all modalities (that is, ultrasound, CT/CTA, and MRI/MRA studies) that were frequently performed on a single day based on historical claims data. Using PE input data provided by the RUC, we factored out the clinical staff minutes for the activities we indicated are not duplicated for subsequent procedures, and the supplies, other than film, which we consider are not duplicated for subsequent procedures. As noted previously, equipment time and indirect costs are allocated based on clinical labor time; therefore, these inputs were reduced accordingly. Removing the PE inputs for activities that are not duplicated, and adjusting the equipment time and indirect costs for the individual pairs of procedures studied, supports payment reductions ranging from 40 to 59 percent for the subsequent services. Because we found a relatively narrow range of percentage payment reductions across modalities and families, and taking into consideration that we did not eliminate any duplicative image acquisition time for subsequent procedures in our analysis, we decided that an across-the-board reduction for all 11 families of 50 percent (which is approximately the midpoint of the range established through our analysis) was both justified and conservative. We believe this payment reduction policy represents an appropriate reduction for the typical delivery of multiple imaging services in all 11 families. Because the reduction is based on eliminating the specific practice expense inputs that are not duplicated, we believe the proposal is consistent with the resource-based practice expense methodology.

While various alternative reduction percentages were suggested, no evidence was presented to support specific alternative percentages. However, we recognize that many commenters raised significant objections and we appreciate their comments indicating their specific concerns regarding the appropriate reductions for each family and specific combinations of services within families.

To allow for a transition of the changes in payments for these services attributable to this reduction policy, and provide a further opportunity for comment, we have decided to phase-in the policy over 2 years. We will implement a 25 percent payment reduction in CY 2006 and a 50 percent reduction for all 11 families in CY 2007 for all code families, unless we find upon further review during the upcoming year that modifications to this policy are appropriate. To enhance our review, we are soliciting, from providers of diagnostic imaging services, comprehensive data regarding the efficiencies associated with different combinations of imaging services in the 11 families. We welcome the opportunity to have other discussions with the physician community on these issues.

Comment: One commenter noted that a patient having both a pelvic and transvaginal ultrasound often needs a break between procedures and requires repositioning, along with the use of a different probe for the second study. The commenter also noted that breast and pelvic ultrasounds are often performed in different locations and by different physicians.

Response: The commenter has raised some serious questions concerning whether any payment reduction is appropriate for the procedures indicated. Therefore, we have decided to delete transvaginal ultrasound and ultrasound of the breast(s) (CPT codes 76830 and 76645, respectively) from the list of procedures in family one subject to the payment reduction, pending further study. We believe there may be common clinical scenarios where these services are provided in combination with other ultrasound studies where payment reduction may not be appropriate. These typical efficiencies associated with these services when provided in combination with other studies in family one require further study.

Comment: Many commenters asked how ''single session'' is defined and what mechanism will be used to distinguish single and multiple sessions. One commenter indicated that multiple procedures are frequently performed in separate rooms within the radiology department or in different areas within the hospital. In these cases, the patient must be transported from one room to another and the process restarted. One commenter noted the potential for abuse by self-referring physicians writing separate prescriptions for studies on different days. Another commenter indicated that the proposal will force providers to schedule further studies on additional days.

Response: We consider a single session to be one encounter where a patient could receive one or more radiological studies. If more than one of the imaging services in a single family

is provided to the patient during one encounter, then this would constitute a single session and the lower-priced procedure(s) would be reduced. On the other hand, if a patient has a separate encounter on the same day for a medically necessary reason and receives a second imaging service from the same family, we consider these multiple studies in the same family on the same day to be provided in separate sessions. In the latter case, we have established that the physician should use modifier -59 to indicate multiple sessions, and that the multiple procedure reduction does not apply. Medicare carriers will establish edits to ensure that separate sessions are not inappropriately scheduled for contiguous body area imaging in attempts to bypass the reduction. Use of the modifier where not medically necessary in order to bypass the payment reduction constitutes fraud.

Comment: One commenter suggested that the proposal required multiple body area imaging whenever a procedure in a particular family was performed, resulting in unnecessary imaging. Another commenter stated that grouping procedures to justify lower reimbursement provides no medical or monetary benefit and is detrimental to patient care.

Response: It appears the commenters have misinterpreted our proposal. The proposal in no way requires the performance of unnecessary multiple imaging procedures when only a single study is medically necessary. The families of procedures are based on claims data indicating that these procedures are often done in combination, most likely in a single session. We believe that the payment reduction for the lower-priced imaging procedures from one family performed on contiguous body areas provides the most appropriate payments for the services provided.

Comment: A few commenters recommended that we apply the budget neutrality adjustment only to PE RVUs and not to work RVUs.

Response: The commenters are correct that, because the payment reduction applies only to PE RVUs, the savings should likewise only apply to PE RVUs. We agree with this comment and have made the necessary adjustment.

Comment: One commenter indicated that we should request a statutory change to exempt the proposal from budget neutrality.

Response: We believe it is up to the Congress to decide whether it wants to make adjustments to the application of budget neutrality. We have no plans to request this change.

Final Decision

We have revised our proposal as follows:

- Phase in the payment reduction, with a 25 percent reduction in CY 2006 and a 50 percent reduction in CY 2007. Our review of the multiple imaging payment reduction policy will be ongoing.
- Deleting CPT codes 76830 and 76645 from the list of procedures in family one subject to the reduction, pending further study.
- Applying the budget neutrality adjustment only to PE RVUs, rather than to both work and PE RVUs.

An example of the current and CY 2006 payments is summarized in Table 26, and the revised lists of procedures subject to the reduction, are set forth in Table 27:

TABLE 26.—EXAMPLE OF PAYMENTS

	Procedure 1 74183	Procedure 2 72196	Current total payment	CY 2006 total payment	CY 2006 payment calculation
PC	$117.00	$90.00	$207.00	$207.00	no reduction.
TC	978.00	529.00	1,507.00	1,374.75	978 + (.75 × $529).
Global	1,095.00	619.00	1,714.00	1,581.75	$207 + $978 + (0.75 × $529).

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TABLE 27: List of Diagnostic Imaging Services (by Family)

Family 1 Ultrasound (Chest/Abdomen/Pelvis - Non-Obstetrical	
76604	US exam, chest, b-scan
76700	US exam, abdom, complete
76705	Echo exam of abdomen
76770	US exam abdo back wall, comp
76775	US exam abdo back wall, lim
76778	US exam kidney transplant
76831	Echo exam, uterus
76856	US exam, pelvic, complete
76857	US exam, pelvic, limited
Family 2 CT and CTA (Chest/Thorax/Abd/Pelvis)	
71250	CT thorax w/o dye
71260	CT thorax w/ dye
71270	CT thorax w/o & w/ dye
71275	CT angiography, chest
72191	CT angiography, pelv w/o & w/ dye
72192	CT pelvis w/o dye
72193	CT pelvis w/ dye
72194	CT pelvis w/o & w/ dye
74150	CT abdomen w/o dye
74160	CT abdomen w/ dye
74170	CT abdomen w/o & w/ dye
74175	CT angiography, abdom w/o & w/ dye
75635	CT angio abdominal arteries
0067T	CT colonography; dx
Family 3 CT and CTA (Head/Brain/Orbit/Maxillofacial/Neck)	
70450	CT head/brain w/o dye
70460	CT head/brain w/ dye
70470	CT head/brain w/o & w/ dye
70480	CT orbit/ear/fossa w/o dye
70481	CT orbit/ear/fossa w/ dye
70482	CT orbit/ear/fossa w/o & w/ dye
70486	CT maxillofacial w/o dye
70487	CT maxillofacial w/ dye
70488	CT maxillofacial w/o & w/ dye
70490	CT soft tissue neck w/o dye
70491	CT soft tissue neck w/ dye
70492	CT soft tissue neck w/o & w/ dye
70496	CT angiography, head
70498	CT angiography, neck
Family 4 MRI and MRA (Chest/Abd/Pelvis)	
71550	MRI chest w/o dye
71551	MRI chest w/ dye
71552	MRI chest w/o & w/ dye
71555	MRI angio chest w/ or w/o dye
72195	MRI pelvis w/o dye
72196	MRI pelvis w/ dye
72197	MRI pelvis w/o &w/ dye
72198	MRI angio pelvis w/ or w/o dye
74181	MRI abdomen w/o dye
74182	MRI abdomen w/ dye
74183	MRI abdomen w/o and w/ dye
74185	MRI angio, abdom w/ or w/o dye
Family 5 MRI and MRA (Head/Brain/Neck)	
70540	MRI orbit/face/neck w/o dye
70542	MRI orbit/face/neck w/ dye
70543	MRI orbit/face/neck w/o & w/dye
70544	MR angiography head w/o dye
70545	MR angiography head w/dye
70546	MR angiography head w/o & w/dye
70547	MR angiography neck w/o dye
70548	MR angiography neck w/dye

70549	MR angiography neck w/o & w/dye
70551	MRI brain w/o dye
70552	MRI brain w/dye
70553	MRI brain w/o & w/dye
Family 6 MRI and MRA (spine)	
72141	MRI neck spine w/o dye
72142	MRI neck spine w/dye
72146	MRI chest spine w/o dye
72147	MRI chest spine w/dye
72148	MRI lumbar spine w/o dye
72149	MRI lumbar spine w/dye
72156	MRI neck spine w/o & w/dye
72157	MRI chest spine w/o & w/dye
72158	MRI lumbar spine w/o & w/dye
Family 7 CT (spine)	
72125	CT neck spine w/o dye
72126	CT neck spine w/dye
72127	CT neck spine w/o & w/dye
72128	CT chest spine w/o dye
72129	CT chest spine w/dye
72130	CT chest spine w/o & w/dye
72131	CT lumbar spine w/o dye
72132	CT lumbar spine w/dye
72133	CT lumbar spine w/o & w/dye
Family 8 MRI and MRA (lower extremities)	
73718	MRI lower extremity w/o dye
73719	MRI lower extremity w/dye
73720	MRI lower ext w/ & w/o dye
73721	MRI joint of lwr extre w/o dye
73722	MRI joint of lwr extr w/dye
73723	MRI joint of lwr extr w/o & w/dye
73725 - MRA	MR angio lower ext w or w/o dye
Family 9 CT and CTA (lower extremities)	
73700	CT lower extremity w/o dye
73701	CT lower extremity w/dye
73702	CT lower extremity w/o & w/dye
73706	CT angio lower ext w/o & w/dye
Family 10 MR and MRI (upper extremities and joints)	
73218	MRI upper extr w/o dye
73219	MRI upper extr w/dye
73220	MRI upper extremity w/o & w/dye
73221	MRI joint upper extr w/o dye
73222	MRI joint upper extr w/dye
73223	MRI joint upper extr w/o & w/dye
Family 11 CT and CTA (upper extremities)	
73200	CT upper extremity w/o dye
73201	CT upper extremity w/dye
73202	CT upper extremity w/o & w/dye
73206	CT angio upper extr w/o & w/dye

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K. Therapy Cap

As discussed in the August 8, 2005 proposed rule, section 1833(g)(1) of the Act applies an annual, per beneficiary combined cap on outpatient physical therapy and speech-language pathology services, and a similar separate cap on outpatient occupational therapy services under Medicare Part B. While Section 624 of the MMA placed a moratorium on the application of these caps from December 8, 2003 through December 31, 2005, the caps will become effective again beginning January 1, 2006. (The caps were last implemented from September 1, 2003 through December 7, 2003.) Section 1833(g)(2) of the Act provides that, for 1999 through 2001, the caps were $1500, and for years after 2001, the caps are equal to the preceding year's cap increased by the percentage increase in the MEI (except that if an increase for a year is not a multiple of $10, it is rounded to the nearest multiple of $10).

All of the comments we received questioned the use of therapy caps as a way to ensure beneficiaries get needed service while constraining the growth in spending. The large majority also pointed out the negative effects the therapy caps had on beneficiaries and providers when they were last implemented. However, most of the commenters recognized that we do not have the authority to change the caps. Commenters also wrote in support of an extended moratorium; separating physical therapy and speech-language pathology into two caps; a condition-based payment system; a pay-for-performance system; and a demonstration to assess one or more alternative limitation methods.

We will implement therapy caps on January 1, 2006 according to the statute. We note that significant progress has been made toward the challenging goal of establishing a payment policy ''based on the classification individuals'' as required by the Congress in the BBA section 4541(d)(2) and again in the BBRA section 221(c)(2)(B). First, in order to evaluate Medicare payments for therapy services, we developed a method of identifying therapy services and their individual costs on Medicare claim lines. Then, we identified classification groups and conducted initial analyses of the type and amount of treatment utilized by each group. These 21 classification groups consisted of patients whose conditions were similar based on ICD–9 diagnosis codes, utilization patterns, published research and clinical opinion that indicated they may have similar health risk and require similar level of care and expenditures for service. For example, spinal cord injury, hip fracture, and musculoskeletal disorders form classifications that include many similar diagnoses. This demonstrated that if the expected need for service can be determined for subsets of each classification group, system edits that limit spending based on expected needs are feasible and would result in cost savings. To implement a payment method based on the conditions described by classification groups, additional information is needed on the claim about the patient's need for therapy services. Indicators or measurements that represent need, such as severity and acuity of a patient's condition, are not available on the current Medicare claim form and are not consistently gathered or reported by therapists. In order to be useful, these factors must be obtained from a sufficiently large database of patients to predict patients' needs with statistical validity and reliability. We currently have studies underway to extend the progress made in prior studies to explore the potential for using patient condition information to predict therapy needs and likely outcomes. We expect these studies to be completed in 2006.

After issuance of this rule, we will issue instructions to contractors related to the implementation of therapy caps. We will consider comments received in response to the August 8, 2005 proposed rule as we develop those instructions. Since 2003, we have maintained, and we recently updated, a web site that describes therapy caps. We encourage providers and beneficiaries to review that information at *www.cms.hhs.gov/medlearn/therapy* (Therapy Cap Status).

Based on the formula established in 1883(g)(2) of the Act, the therapy caps will be implemented January 1, 2006. The dollar amount for the therapy caps for CY 2006 is $1,740.

L. Chiropractic Demonstration Discussion

Section 1861(r)(5) of the Act limits current Medicare coverage for chiropractic treatment by means of the manual manipulation of the spine for the purpose of correcting a subluxation, defined generally as a malfunction of the spine. Specifically, Medicare covers three CPT Codes provided by chiropractors: 98940 (manipulative treatment, 1–2 regions of the spine); 98941 (manipulative treatment, 3–4 regions of the spine); and 98942 (manipulative treatment, 5 regions of the spine). Treatment must be provided for an active subluxation only, and not for prevention or maintenance. Additionally, treatment of the subluxation must be related to a neuromusculoskeletal condition where there is a reasonable expectation of recovery or functional improvement.

In the August 8, 2005 proposed rule, we included a discussion of the 2-year demonstration authorized by Section 651 of the MMA to evaluate the feasibility and advisability of covering additional chiropractic services under Medicare. These services extend beyond the current coverage for manipulation to care for neuromusculoskeletal conditions typical among eligible beneficiaries, and cover diagnostic and other services that a chiropractor is legally authorized to perform by the State or jurisdiction in which the treatment is provided. Physician approval will not be required for these services. The demonstration is being conducted in four sites, two rural and two urban. One site of each area type must be a health professional shortage area (HPSA). The demonstration must also be budget neutral. The statute requires the Secretary to ensure that aggregate payments made under the Medicare program do not exceed those that would be paid in the absence of this demonstration.

Ensuring budget neutrality requires that the Secretary develop a strategy for recouping funds should the demonstration result in costs higher than would occur in the absence of the demonstration. In this case, we would make adjustments in the national chiropractor fee schedule to recover the costs of the demonstration in excess of the amount estimated to yield budget neutrality. We will assess budget neutrality by determining the change in costs based on a pre/post comparison of costs and the rate of change for specific diagnoses that are treated by chiropractors and physicians in the demonstration sites and control sites. We will not limit our analysis to reviewing only chiropractor claims, because the costs of the expanded chiropractor services may have an impact on other Medicare costs.

Any needed reduction would be made in the CY 2010 and CY 2011 fee schedules as it will take approximately 2 years to complete the claims analysis. If we determine that the adjustment for budget neutrality is greater than 2 percent of spending for the chiropractor fee schedule codes (comprised of the 3 currently covered CPT codes 98940, 98941 and 98942), we will implement the adjustment over a 2-year period. However, if the adjustment is less than 2 percent of spending under the chiropractor fee schedule codes, we will implement the adjustment over a 1-year period. We will include the detailed

analysis of budget neutrality and any proposed offset in the CY 2009 **Federal Register** publication of the PFS.

We also noted in the proposed rule that PT services performed by chiropractors under the demonstration will be included under the PT cap described in section II.K. of the preamble to this final rule with comment. These services are included under the cap because chiropractors are subject to the same rules as medical doctors for therapy services under the demonstration.

The following is a summary of the comments received and our responses.

Comment: Several commenters expressed concern regarding specific aspects of the demonstration project, including PT services being provided by chiropractors and including the PT services provided by chiropractors under the demonstration under the therapy cap.

Response: A discussion of the chiropractic demonstration was included in the PFS proposed rule because of the potential for a budget neutrality adjustment that will be discussed in the CY 2009 **Federal Register** publication of the PFS. Issues concerning the demonstration project itself were outside the scope of the proposed rule. We are including PT services provided by chiropractors under the therapy cap because under the demonstration, we are subjecting chiropractors to the same rules as physicians for therapy services.

Comment: One commenter suggested that in the calculation of the budget neutrality of the demonstration project that the therapy rendered by the chiropractors or their therapists is a ''trade off'' of associated costs that would have required evaluation, order and recertification by a medical doctor. They also suggested that the management of neuromuscular conditions is more efficient when all contributing factors are identified and addressed simultaneously by the combined skills of each specialty. The patient would normally learn to function more rapidly through concurrent multidisciplinary management than with any limited single approach. In addition, the commenters noted that to accurately assess the demonstration a variety of variables, such as medical services that were not required or services directly replaced by another provider, need to be considered.

Response: Section 651(a)(1) specified that the chiropractic services provided under the demonstration should include diagnostic and other services that a chiropractor is legally authorized to perform by the State or jurisdiction in which the treatment is provided. There is no requirement for concurrent multidisciplinary management of neuromuscular conditions. We recognize that covering additional services by chiropractors could have an impact on currently covered Medicare services. For this reason, we plan to assess budget neutrality by examining the total Medicare costs for specific diagnoses, and not just the chiropractor costs. As we noted previously, we will provide a detailed analysis of budget neutrality and any proposed offset in the CY 2009 **Federal Register** publication of the PFS.

Comment: Commenters requested that we clarify plans for making reductions to maintain budget neutrality and identify claims we will analyze. The commenters also requested that we provide information on how this will impact the SGR, particularly if the chiropractic demonstration results in increased spending on physicians' services, since this could result in reductions in reimbursement for all physicians, not just chiropractors. Another commenter opposed the application of any adjustments to the national chiropractic fee schedule instead of an adjustment to the overall fee schedule. This commenter believes that the totality of funds under part B and not subset of services within it should finance the demonstration program and that this is reflected in section 651(f)(A)of the MMA.

Response: Section 651(f)(A) requires that ''* * * the Secretary shall ensure that the aggregate payment made by the Secretary under the Medicare program do not exceed the amount which the Secretary would have paid under the Medicare program if the demonstrations projects under this section were not implemented.'' The legislation does not specify a specific methodology for ensuring budget neutrality. Our methodology meets the legislative intent, and appropriately impacts the profession that is directly affected by the demonstration.

Because the demonstration is located in only four sites in which the expansion of services is permitted, we anticipate that the impact on the SGR would be negligible.

M. Supplemental Payments to Federally Qualified Health Centers (FQHCs) Subcontracting With Medicare Advantage (MA) Plans

Section 237 of the MMA amended section 1833(a)(3) of Act to provide supplemental payments to FQHCs that contract with Medicare Advantage (MA) organizations to cover the difference, if any, between the payment received by the FQHC for treating enrollees in MA plans offered by the MA organization and the payment that the FQHC is entitled to receive under the cost-based all-inclusive payment rate as set forth in part 405, subpart X. The supplemental payment for covered Medicare FQHC services furnished to MA enrollees augments the direct payments made by MA plans to FQHCs for covered Medicare FQHC services.

In order to implement this new payment provision, we must determine whether the Medicare cost-based payments to which the FQHC would be entitled exceed the amount of payments received by the center from the MA organization and, if so, pay the difference to the FQHC.

The proposed supplemental payment for FQHC covered services rendered to MA enrollees is equal to the difference between 100 percent of the FQHC's all-inclusive cost-based per-visit rate and the average per-visit rate received by the FQHC from the MA plan in which the enrollee is enrolled, less any amount the FQHC may charge as described in section 1857(e)(3)(B) of the Act.

A supplemental payment will be made every time a face-to-face encounter occurs between an MA enrollee and any one of the FQHC's core practitioners: physician, nurse practitioner, physician assistant, clinical nurse midwife, clinical psychologist, or clinical social worker. The supplemental payment is made directly to each FQHC through the Medicare Fiscal Intermediary (FI).

In the August 8, 2005 proposed rule, we proposed conforming changes to our regulations to add § 405.2469 to provide a supplemental payment, based on a per-visit calculation, to FQHCs under contract (directly or indirectly) with MA organizations.

We received comments on the portion of the proposed rule addressing the FQHC supplemental payment provision of section 237 of the MMA. A summary of those comments and our responses follows:

Comment: One commenter asked how the Medicare contractor will know the amount the health plan paid when FQHCs bill the Medicare contractor for the supplemental payment.

Response: The Medicare contractor will know the amount paid by the MA plan based on the required MA payment estimate furnished by the FQHC to the contractor. The payment amount difference between the interim FQHC all-inclusive cost based rate and the average interim MA rate will be reported on the FQHC claim form every time the FQHC submits a bill to the

contractor to collect an FQHC supplemental payment. The Medicare contractor will pay FQHCs the difference between the interim FQHC all-inclusive rate and the interim MA rate on a per-visit basis.

Comment: A commenter requested clarification regarding cost sharing rules for MA enrollees as referenced in § 405.2469(a)(ii), which stipulates that FQHCs may charge Medicare patients as described in section 1857(e)(3)(B) of the Act.

Response: Section 1857(e)(3)(B) of the Act provides that a FQHC must accept the MA payment and the Federal supplemental payment (that is, the payment decribed in section 1833(a)(3)(B)) as payment in full for services covered by the agreement, except that the FQHC may collect any amount of cost-sharing permitted under the MA contract, so long as the amounts of any deductible, coinsurance, or co-payment comply with the requirements under section 1854(e) of the Act. In general, an MA plan offered by an MA organization satisfies section 1854(e) of the Act beginning in 2006 if the monthly basic MA premium and the actuarial value of the cost sharing charged to enrollees for services covered under Parts A and B of original Medicare do not exceed the actuarial value of cost sharing charged to beneficiaries in original Medicare. MA plans must also disclose cost sharing amounts to their members.

Comment: Two commenters urged us to deduct from the supplemental payment calculation only the amount of cost-sharing actually collected by the FQHC. Furthermore, the commenters asked that we recognize any uncollected cost-sharing amounts as ''bad debt'' on the FQHC cost report.

Response: The supplemental payment calculation shall deduct the cost sharing amounts set forth in the formal contract between the FQHC and MA plan, not the actual amounts collected by the FQHC. Section 1833(a)(1)(B) states that the supplemental payment is to be calculated net of any amount the FQHC ''may charge'' as described in section 1857(e)(3)(B) of the Act. Thus the language of the statute plainly states that the supplemental payment is to be based on what the FQHC could charge as cost sharing, not cost sharing amounts that the FQHC actually collects.

Rules regarding what may constitute ''bad debt'' for purposes of a FQHC's cost report are beyond the scope of this final rule with comment. Furthermore, the rules we are finalizing pertain to section 237 of the MMA which addresses a supplemental payment to FQHCs that contract, directly or indirectly, with an MA organization. Thus, arrangements pertaining to ''bad debt'' for uncollected cost sharing owed by an MA plan enrollee, if any, would be governed by the contract between the FQHC and the MA organization.

Comment: A commenter questioned whether the upper payment limit would apply in determining the supplemental payment.

Response: For FQHCs operating below the FQHC national payment limit, we will use their actual per-visit all-inclusive rate to determine the FQHC supplemental. For FQHCs operating at or above the national payment limit, we will use the applicable national FQHC urban or rural upper limit to calculate the FQHC supplemental payment. The amount of the supplemental payment will be the amount by which the original FQHC payment exceeds the MA plan payment. Section 237 of the MMA clearly requires the use of a cost-based rate or based on other tests of reasonableness as the Secretary may prescribe in regulations. The longstanding national FQHC payment limit is an integral part of the FQHC payment methodology as set forth in regulations.

Comment: A commenter questioned whether the provider types listed on page 45853 (Proposed Payment Methodology Section) of the August 8, 2005 proposed rule is broader than the original FQHC benefit.

Response: In the proposed rule, we explained that an FQHC supplemental payment is made only when a face-to-face encounter occurs between a core FQHC practitioner and an MA enrollee. This list of core FQHC practitioners is identical to the practitioner list for the original FQHC Medicare benefit. Furthermore, these FQHC practitioners must meet all applicable qualification requirements as set forth in section 405 and 491 of the CFR in order to qualify for the supplemental payment.

Comment: A commenter requested that we amend the regulatory definition of eligible centers for the FQHC supplemental payments to allow payments for health centers for the homeless. The preamble of the proposed rule states that eligible FQHCs include all centers receiving grants under Section 330 except those centers that receive funds pursuant to Section 330(h) of the Public Health Service Act (that is, Health Care for the Homeless grantees). The commenter specifically requested that we recognize these centers for supplemental payments, or at a minimum, be prepared to do so as soon as legislation is passed.

Response: We currently do not have the statutory authority to recognize as Medicare FQHCs any entity that does not meet statutory requirements for designation as an FQHC. Consequently, we cannot provide centers that are not FQHCs with Medicare FQHC supplemental payments for treating MA enrollees. If changes were made to the statute, we would implement regulations, as necessary, consistent with statutory requirements.

Comment: A commenter asked for clarification regarding the statement in the rule that FQHCs under contract (indirectly or directly) with MA organizations are eligible for supplemental payments. The commenter requested specific confirmation that the term ''indirect'' is intended to include arrangements under which the health center contracts with another organization, which in turn, contracts with the MA organization in order to provide Medicare services.

Response: We interpreted section 237 of the MMA to mean that any Medicare FQHC furnishing covered FQHC services to MA plan enrollees would be eligible for supplemental payments regardless of whether they have a direct contract with an MA organization or contract with another entity (for example, a medical group) that has a direct contract with the MA organization to treat its enrollees.

Comment: A commenter asked whether a health center with an MA contract can bill Medicare directly on a fee-for-service basis if the center provides services to plan enrollees that are not FQHC services. For example, can they directly bill for services the FQHC could otherwise bill as Part B services if it were not providing the service to an MA plan enrollee? A commenter requested clarification whether a health center will be allowed to bill original Medicare for extended hours of operation not included under the center's MA arrangement. Another commenter asked whether a health center that utilizes a specialist, who is not included in the MA plan's specialty panel, to provide an FQHC core service will be permitted to bill Medicare for these services.

Response: The FQHC should bill original Medicare only for covered services rendered to original Medicare beneficiaries that are ''not'' enrolled in an MA plan. In accordance with section 1851(i) of the Act, with limited exceptions, only the MA organization is entitled to receive Medicare payments for services furnished to its enrollees. Therefore, FQHCs under direct or indirect contract with an MA organization must look to the MA

organization for payment. The additional payment permitted by section 1833(a)(3)(B) of the Act applies only to FQHC services described in section 1832(a)(2)(D)(ii) of the Act.

Comment: A commenter questioned whether services not covered under original Medicare, but offered and paid for by the MA plan, such as dental, are included in determining the CMS wrap-around payment to the center.

Response: Only services meeting the definition of an FQHC service as defined under section 1832(a)(2)(D) of the Act are included in the determination of the FQHC supplemental payment. Thus, services other than those defined under section 1832(a)(2)(D), such as dental services, are not included in the determination of the supplemental payment.

Comment: A commenter requested that we modify our proposed FQHC supplemental payment methodology to include Medicare FQHC covered services that are not necessarily performed as a face-to-face encounter.

Response: All covered Medicare FQHCs services are eligible for supplemental payments regardless of whether these services trigger a billable FQHC visit. For purposes of consistency, we adopt the longstanding FQHC visit definition under original Medicare, which would provide a supplemental payment every time there is a face-to-face encounter between an MA enrollee and one or more of the following FQHC covered core practitioners: physicians, nurse practitioners, physician assistants, clinical nurse midwives, clinical psychologists, or clinical social workers. The costs of services incidental to the professional services of the above core FQHC practitioners would be bundled into the calculation of the supplemental payment. In light of the fact that all incidental services and costs are recognized, we believe that the use of the FQHC encounter definition for the supplemental payment provision is reasonable and appropriate.

Comment: A commenter requested clarification regarding the interim rate that should be utilized for these health centers in light of the fact that centers have yet to have their annual reconciliation from 2004 performed.

Response: The interim rate for MA payments will be based on estimates from the contracting FQHC until actual MA payments and visits are captured on the FQHC cost report. We will use these estimates until actual MA payments and visits are captured on the FQHC cost reports. At that point, payments will be adjusted accordingly.

Comment: A commenter asked for clarification regarding which fiscal year would apply to the rate calculation methodology for services rendered on or after January 1, 2006—the Federal fiscal year, the health center, or the MA plan. Furthermore, clarification was requested regarding the transition process for reconciling differences between centers' fiscal year and the MA contract year.

Response: The FQHC supplemental payment calculation shall be based on the FQHC's cost report year. For the initial year, if the MA plan's contract year and the FQHC's fiscal year do not coincide, the FQHC supplemental payment calculation shall be based on a weighted average of MA payments based on the number of MA visits expected in each respective MA contract year. In subsequent FQHC cost report years, actual MA payments and visits will be used to calculate final FQHC supplemental payments as well as the interim supplemental payments for the following year. Since actual payments and visits already reflect the differences between the FQHC fiscal year and the MA contract year, no transition process is necessary.

Comment: A commenter requested clarification whether payments will be aggregated across multiple MA plans or whether the payments will be plan specific.

Response: In cases where an FQHC has multiple arrangements in place with different MA plans, payments will be aggregated across multiple plans to determine final Medicare program liability. In other words, at cost settlement MA payments will be aggregated for all MA enrollees treated by the FQHC.

Comment: A commenter expressed concern that the required detailed MA payment estimates from FQHCs will result in a significant increase in administrative time. In light of this new requirement, they suggested that we develop standard forms and information requests to ease the burden as much as possible.

Response: Each eligible FQHC seeking the supplemental payment is required to submit (for the first two rate years) to the Medicare Fiscal Intermediary (FI) an estimate of the average MA payments (per-visit basis) for covered FQHC services provided to MA enrollees. Every eligible FQHC seeking the supplemental payment is required to submit a documented estimate of its average per-visit payment for MA enrollees in each MA plan offered by the MA organization and any other information as may be required to enable the FI to accurately establish an interim supplemental payment. Expected payments from the MA organization would be used only until actual MA revenue and visits collected on the FQHC's cost report can be used to establish the amount of the supplemental payment. Until we modify the FQHC cost report form to identify and capture MA payments and visits, each eligible FQHC requesting supplemental payments will be required to submit estimates to CMS.

Comment: A commenter urged us to calculate and provide supplemental payments on a per-visit basis to ensure adequate cash flow to contracting FQHCs.

Response: Under the proposed rule, we added § 405.2469 to specify that the FQHC supplemental payment methodology is on a per-visit basis.

Comment: A commenter requested timely annual system reviews of cost reports to ensure that the health centers are provided with a continuous cash flow of Medicare funding.

Response: The Medicare contractors responsible for processing FQHC claims and reviewing cost reports will use all available resources for timely cost report settlement.

Comment: A commenter requests that we provide guidance under this rule regarding the methods of enforcing the statutory requirement that MA plan payments to contracting FQHCs must be comparable to other contracting health care providers furnishing similar services.

Response: Generally, we will examine contracts and attendant fee schedules between MA organizations and FQHCs and between MA organizations and other providers to ensure that payment levels for similar services are comparable.

Comment: A commenter requested clarification regarding how our cross-over system will work for MA enrollees who are dually-eligible for the Medicare and Medicaid programs. They asked if claims for dually-eligible patients will be forwarded to the Medicaid agency by the MA plan or by CMS.

Response: Our crossover processes do not apply to MA claims but rather to claims that are processed under original Medicare, fee-for-service contractor operations. Therefore, claims for persons who have enrolled in an MA plan will not be crossed over by CMS. The MA plan would need to coordinate with Medicaid.

Comment: A commenter expressed concern about the appeals process for circumstances under which the MA plan denies a claim, which would result in our denial of the supplemental payment. They asked what procedures

the health center should follow when faced with this situation.

Response: If an FQHC signs a waiver of liability, the FQHC may utilize the MA appeals process at 42 CFR part 422, subpart M to contest an MA organization's payment denial. If the MA organization's claim denial is overturned upon appeal, CMS will make a supplemental payment to a FQHC.

Comment: A commenter requested that we work with MA plans on establishing an expedited credentialing process to ensure that all health center providers are credentialed on a timely basis, preferably prior to January 1, 2006.

Response: The requirements related to credentialing MA plan providers are found in subpart E the Part 422. Note that with limited exceptions, the credentialing process that MA organizations follow for providers is at the MA organization's discretion (see § 422.204).

Comment: A commenter requested clarification that supplemental payments are available for Medicare-covered services provided by FQHCs under non-traditional managed care approaches, such as Preferred Provider Organization (PPOs).

Response: FQHCs contracting with any MA organization are eligible for supplemental payments. MA organizations can offer various types of MA plans, including PPOs.

We are revising § 405.2469 as proposed with one change, the first use of the term ''Medicare Advantage plans'' is revised to read ''Medicare Advantage organizations.''

N. National Coverage Decisions Timeframes

We have established requirements concerning the administrative review of local coverage determinations (LCDs) and National Coverage Determinations (NCDs) at 42 CFR part 426, with subpart C specifically addressing the general provisions for the review of LCDs and NCDs. We are updating these requirements as they apply to NCDs to reflect changes in the statute.

Under our existing regulations in part 426, Subpart C, the Departmental Appeals Board may stay the adjudicatory proceedings in certain circumstances to allow CMS to consider significant new evidence that is submitted in the context of a challenge to an NCD. Our previous regulations at § 426.340(e), permitted a brief stay of the adjudicatory proceedings (not more than 90 days), for CMS to complete its reconsideration of the NCD. Those timeframes, although short, were consistent with the previous process for making NCDs that did not require publication of a proposed decision memorandum and an opportunity for public comment on the proposed decision memorandum.

As discussed in the August 8, 2005 proposed rule (70 FR 45853), based on the provisions of section 731 of the MMA of 2003, we proposed to amend § 426.340 to state that if the CMS informs the Board that a revision or reconsideration was or will be initiated, then the Board will stay the proceedings and set appropriate timeframes by which the revision or reconsideration will be completed, that reflects sufficient time for the publication of a proposed determination, a 30-day public comment period, and time for CMS to prepare a final determination that responds to public comments as specified in section 1862(l) of the Act. We also proposed to eliminate the reference to the 90-day reconsideration period in § 426.340(e)(3) for NCD appeals to reflect the new timeframes in the MMA.

Comment: We received 7 comments regarding the proposed NCD timeframes. All commenters supported the change. However, a few commenters raised concerns about the delays regarding a specific NCD that was initiated before the December 8, 2003 effective date for the statutory change.

Response: We will finalize the changes to § 426.340 as proposed with minor technical edits, and will continue to work diligently to assure that all NCDs submitted after the December 8, 2003 effective date for the statutory change are developed within the set timeframes.

O. Coverage of Screening for Glaucoma

On January 1, 2002, we implemented regulations at § 410.23(a)(2), Conditions for and limitations on coverage of screening for glaucoma, requiring that the term ''eligible beneficiary'' be defined to include individuals in the following high risk categories: Individuals with diabetes mellitus; individuals with a family history of glaucoma; or African-Americans age 50 and over. As discussed in the August 8, 2005 proposed rule (70 FR 45853) based on our review of the current medical literature, we believe that there are other beneficiaries who are at risk for glaucoma and should be included in the definition of eligible beneficiary for purposes of the glaucoma screening benefit.

We believe the evidence is adequate to conclude that Hispanic persons age 65 and older are at high risk and could benefit from glaucoma screening.

Therefore in § 410.23(a)(2), we proposed to revise the definition of an eligible beneficiary to include Hispanic Americans age 65 and over. In view of the possibility that it may be appropriate to include other individuals in the definition of those at ''high risk'' for glaucoma, we also requested comments on this issue, including documentation from the peer-reviewed medical literature in support of suggested changes.

We received seven comments on the proposal to expand coverage of the glaucoma screening benefit to include Hispanic Americans within the category of those individuals at ''high risk'' for glaucoma. The following is a summary of the comments received and our responses.

Comment: One commenter stated that it might be appropriate to include other individuals (and not only Hispanic-Americans over age 65) in the definition of those at ''high risk'' for glaucoma. The commenter cited the Los Angeles Latino Eye Study and the research conducted by the Eye Diseases Prevalence Research Group as illustrating a sharp rise in the prevalence of glaucoma among Hispanic-Americans beginning at age 60 (Archives of Ophthalmology 2004; 122:532–538). The commenter indicated that according to the latter research, the risk of developing glaucoma among Hispanics between the ages 50–59 is 2.92 percent, and that this number increases significantly to 7.36 percent for Hispanics between the ages 60–69. In view of this increase in the prevalence of glaucoma in the Hispanic population between the ages 60–69, the commenter recommended that CMS reduce the proposed screening coverage age from 65 to 60 years of age, suggesting that this lowering of the age would allow for medical intervention at an earlier stage during this critical period for glaucoma development.

Response: We note that the commenter relied on the results of a major study (See the Archives Ophthalmology 2004; 122:532–538) in offering their suggestion for revising the proposal. That, in turn, relied on the results of another major study (See Archives of Ophthalmology 2001; 119:1819–1826) for data on incidence and prevalence of primary open angle glaucoma in Hispanic-Americans. The latter study (Quigley, et al.) contains a graph on page 1822 which, in addition to stating the same data that the commenter referenced, shows an acceleration in prevalence of open angle glaucoma in Hispanic-Americans as compared to White persons beginning at age 65. This study by Quigley et al.

yields data supporting a higher incidence of open angle glaucoma in Hispanics as compared to Whites beginning at age 65 (Quigley, HA et al). The prevalence of glaucoma in a population based study of Hispanic subjects: proyecto VER. (Annals of Ophthalmology 2001; 119:1819–1825). Though they are not statistically significant in that age group, the data strongly favors our conclusion. However, for ages under 65 years, the evidence is poor for any differences in these 2 groups for an incidence of open angle glaucoma. Therefore, we have chosen a coverage baseline for the glaucoma screening benefit of age 65 and older for Hispanic-Americans.

Comment: One commenter stated that they did not support the proposal to expand the definition of those individuals at ''high risk'' for glaucoma because they do not believe there is sufficient evidence in the medical literature to recommend for or against screening adults for glaucoma, including Hispanic-Americans age 65 and older. The commenter cited the United States Preventive Services Task Force (USPSTF) recommendation that concluded that there is insufficient evidence to recommend for or against screening adults for glaucoma. The commenter also noted that while the USPSFT clinical considerations section of its recommendation states that increased ocular pressure, family history, older age, and being of African-American descent place an individual at risk for glaucoma, it makes no mention of Hispanic-Americans. Therefore, the commenter concluded that CMS should not make any changes to the current definition.

Response: As stated previously, the articles in Archives of Ophthalmology, show that the prevalence of glaucoma in Hispanics begins to increase at age 65 markedly when compared to Whites. While the USPSTF concluded that there is insufficient evidence to recommend either for or against screening any adult for glaucoma, section 1861(s)(2)(K) of the Act mandates coverage of screening for glaucoma for individuals determined to be at high risk for glaucoma, individuals with a family history of glaucoma and individuals with diabetes. Based on our review of the two published studies, we believe that the evidence is adequate to conclude that Hispanics age 65 and older meet the definition of individuals at high risk for glaucoma and could benefit from glaucoma screening. Further, since glaucoma is prevalent in Hispanics, we would rather be inclusive rather than exclusive for the screening benefit.

Comment: Two commenters urge CMS to help educate providers and Hispanic beneficiaries to ensure that they are aware of the benefits associated with the new coverage when it is included in the final rule.

Response: We agree and will release appropriate manual and transmittal instructions and information from our educational components for the medical community, including a MedLearn Matters article and fact sheets. We also encourage the medical community to join this effort in educating physicians and beneficiaries by distributing their own communications, bulletins, or other publications. In addition, we have specifically included information on the expanded glaucoma screening benefit in the 2006 English and Spanish versions of the *Medicare and You Handbook*, and we plan to revise the booklet, Medicare's Preventive Services, and the bilingual brochure for Hispanic beneficiaries, to reflect the expanded benefit as well.

Comment: One commenter expressed concern that at the present time, if a glaucoma screening is performed and a disease or condition other than glaucoma is discovered the screening examination will no longer be considered to be a covered service, which may leave providers open to additional financial liability unless they ensure that the patient sign an ABN. The commenter recommends that Medicare should cover screening examinations without regard to the diagnosis that is determined as a result of the screening in a particular case.

Response: The availability of coverage under the screening benefit does not depend on whether or not a disease condition is discovered during the annual screening examination. Medicare covers the screening examination regardless of the findings at the time of the screening examination, but if the provider decides to perform and bill Medicare for the more comprehensive eye exam, the cost of the screening examination is considered bundled into the Medicare payment for the more expensive comprehensive eye examination. For example, if a disease, cataract, or a macular degeneration condition is discovered at the time of the glaucoma screening, the provider may decide to perform a medically necessary comprehensive eye examination and bill Medicare Part B for that more expensive covered service. In this example, it would be inappropriate for the provider to bill Medicare for the less expensive glaucoma screening service as well as the more comprehensive and expensive service because it would be duplicative for Medicare to pay for both services. In this situation, the only eye service that may be billed Medicare is the comprehensive eye examination and it would be presumed that the glaucoma screening service is bundled into the Medicare payment for the comprehensive eye service.

Comment: One commenter suggested that CMS work with the Secretary of HHS to add on beneficiary eligibility for all Medicare covered screening tests to the ASC X12N 270/271 eligibility transaction.

Response: This issue does not fall within the scope of the Medicare PFS regulations; and therefore, we are unable to address it in this final rule with comment.

Comment: Two commenters expressed concern about the statement in the Regulatory Impact Analysis (70 FR 45870) of the proposed rule that stated that the expansion of the benefit to include Hispanic persons age 65 and older ''is not expected to have a significant cost impact on the Medicare program.'' The commenters urge CMS to make available to the public it's calculation of the impact on spending that would result from the proposed increase in glaucoma screening coverage and to reflect these spending increases in the SGR, including increases due to the initial test and all related and follow-up care.

Response: Based on the projected utilization of the expanded glaucoma screening coverage to include Hispanic persons age 65 and older, we estimated in the proposed rule that the expanded benefit would result in an increase in Medicare payments to ophthalmologists or optometrists who will provide these screening tests and related follow-up tests and treatment. However, we noted that this change was not expected to have a significant cost impact on the Medicare program. Based on Medicare Part B carrier claims processing data, we estimate that the program paid for about 1,100 glaucoma screening services in CY 2004 at a cost of about $47,000 for the same time period. While it is not possible to predict how many Hispanic-Americans might take advantage of the new coverage that will be available to them, judging from the impact of the present glaucoma screening benefit on the Medicare costs in CY 2004, we do not believe the expansion will have a significant impact on program costs in CY 2005 and subsequent years.

Comment: One commenter suggested that CMS seek to improve its coverage web site in the future to reflect all changes being considered by the agency—both regulatory and NCD developments—that relate to Medicare

coverage of various preventive services. The commenter stated that providing references to all matters affecting Medicare coverage in one place would provide the pubic with a better understanding of the extent of the agency's efforts in this area.

Response: We note that the regulation and the NCD processes are two separate methods specified in the Medicare statute for developing and publishing national coverage policies. However, we plan to review the commenter's suggestion for providing references on the CMS Coverage web site to all matters—both regulatory and NCD developments—affecting Medicare coverage in the preventive services area.

Final Decision

We are revising the definition of an eligible beneficiary who is at ''high risk'' for glaucoma to include Hispanic-Americans age 65 and older as proposed.

P. Additional Issues

1. Corrections to Conditions for Medicare Payment (§ 424.22)

Two typographical errors in 42 CFR 424.22 were discovered. First, § 424.22(d) erroneously refers to the definition of ''financial relationship'' in ''§ 411.351'' instead of ''§ 411.354''. In addition, footnote 1 of § 424.22(a)(1)(iv) contains an error in the spelling of the word ''hospital.'' Therefore, we are revising § 424.22 to correct these errors.

2. Chemotherapy Demonstration Project

CMS seeks to encourage quality care in all facets of cancer treatment and care by encouraging best clinical practices and quality care. In the CY 2005 final rule, we announced the initiation of a 1 year demonstration project for CY 2005 for office-based oncology services. The authority for this demonstration is based on sections 402(a)(1)(B) and 402(b) of the Social Security Act Amendments of 1967 (Pub. L. 90–248). These provisions allow the Secretary to develop and engage in experiments and demonstration projects to provide incentives for economy while maintaining or improving quality in the provision of health services.

This CY 2005 project focused on three areas of concern often cited by patients undergoing chemotherapy: controlling pain; minimizing nausea and vomiting; and reducing fatigue. Participating practitioners are reporting standardized assessments of patient symptoms at the time of chemotherapy encounters. We are collecting data based on these assessments over the course of chemotherapy treatment to trace changes in patient symptoms, quality of life, and medical responses associated with standardized physician assessment of these important areas.

To facilitate the collection of information, we established new Billing Codes, that is, G–codes, to be reported by practitioners in the demonstration. The codes correspond to four patient assessment levels for each of the three patient symptom areas: Nausea and vomiting; pain; and fatigue. These levels, based on the Rotterdam scale, have already proven effective in measuring patient symptoms associated with cancer care, are easily understood by patients, and are in widespread use. Practices reporting data on all three factors to Medicare qualify for an additional payment of $130 per encounter. By billing the designated codes, the practitioner self–enrolls in the project.

Although we did not include a discussion item or demonstration proposal in the August 8, 2005, proposed physician fee schedule rule, we did release a fact sheet on August 1, 2005, titled, ''Demonstration of Improved Quality of Care for Cancer Patients Undergoing Chemotherapy'' which was posted on our web site. The fact sheet provided background on the demonstration project, shared preliminary data on the results of the demonstration, and indicated that we would continue to consult with its stakeholders about the merits of the program and the utility of the data captured.

We received comments on the proposed rule on the demonstration itself and the specific items in the fact sheet. Some commenters pointed out what they perceived as limitations of the demonstration itself, such as the application of the Part B coinsurance to the demonstration codes. Almost all commenters urged CMS to extend the demonstration project in its current form or revise it to capture better data on quality and outcomes. Several commenters favored extending the demonstration to services provided by other physician specialties, such as rheumatology, gastroenterology, urology, or infectious disease; or to those services currently not included in the framework of the demonstration, such as chemotherapy administration to hospital outpatients or chemotherapy services provided through oral anti-cancer drugs.

One major specialty group opposed the continuation of the demonstration project stating that it is inconsistent with current efforts to build evidence-based medicine into the delivery of high quality care to Medicare patients.

Following extensive discussions with various groups representing the interests of oncologists and advocates for patient care, we have decided to retain the demonstration project for one more year, but we will revise the G-codes for reporting in order to take a further step toward encouraging quality care and promoting best clinical practices that should lead to improved patient outcomes. We will eliminate the CY 2005 G-codes specific to the assessment of patient symptoms, while maintaining our focus on quality cancer care, including the management of debilitating symptoms, to assure the best possible quality of life for cancer patients.

Reconfiguration of the Demonstration for CY 2006

The new 1 year oncology demonstration, applicable to services furnished in CY 2006, will build on the use of G codes to gather more specific information relevant to the quality of care for cancer patients, their treatments, and the spectrum of care they receive from their doctors, and whether or not the care follows clinical guidelines. The project will emphasize evidence-based practice guidelines that have been shown to lead to better patient outcomes as the source for standard of care, permitting us to monitor and encourage quality care to cancer patients. Reporting will no longer be specific to chemotherapy administration services, but instead will be associated with physician E/M visits for established patients with cancer, visits that are frequent and essential to assuring quality of care and life for patients.

The demonstration is available to office-based hematologists/oncologists who provide an E/M service of level 2, 3, 4, or 5 to an established patient, when the service is delivered to a patient with a primary diagnosis of cancer belonging to one of the following major diagnostic categories:

- Breast cancer (invasive).
- Colon cancer.
- Rectal cancer.
- Prostate cancer.
- Lung cancer (either non-small cell or small cell).
- Stomach cancer.
- Esophageal cancer.
- Pancreatic cancer.
- Ovarian cancer.
- Non-Hodgkins Lymphoma.
- Chronic myelogenous leukemia.
- Multiple myeloma.
- Cancer of the head and neck.

E/M services furnished by hematologists/oncologists for patients with other cancers as the principal

diagnosis will not qualify under the demonstration.

We are establishing a 2006 payment amount of $23 for the 1 year oncology demonstration payment. To qualify for the $23 oncology demonstration payment, the physician must submit one G-code from each of the following three categories when an E/M service of level 2, 3, 4, or 5 is billed: (1) The primary focus of the E/M service; (2) the current disease state; and (3) whether current management adheres to clinical guidelines.

We will inform the public on more details of this demonstration through a fact sheet and information on our Web site at *www.cms.hhs.gov/*.

III. Refinement of Relative Value Units for Calendar Year 2006 and Response to Public Comments on Interim Relative Value Units for 2005

[If you choose to comment on issues in this section, please include the caption ''Interim Relative Value Units'' at the beginning of your comments.]

A. Summary of Issues Discussed Related to the Adjustment of Relative Value Units

Section III.B. and III.C. of this final rule with comment describes the methodology used to review the comments received on the RVUs for physician work and the process used to establish RVUs for new and revised CPT codes. Changes to codes on the PFS reflected in Addendum B are effective for services furnished beginning January 1, 2006.

B. Process for Establishing Work Relative Value Units for the 2005 Physician Fee Schedule

Our CY 2005 final rule (69 FR 66236) contained the work RVUs for Medicare payment for existing procedure codes under the PFS and interim RVUs for new and revised codes beginning January 1, 2005. We considered the RVUs for the interim codes to be subject to public comment under the annual refinement process. In this section, we summarize the refinements to the interim work RVUs published in the CY 2005 final rule and our establishment of the work RVUs for new and revised codes for the 2006 PFS.

C. Work Relative Value Unit Refinements of Interim Relative Value Units

1. Methodology (Includes Table Titled ''Work Relative Value Unit Refinements of the 2004 Interim and Related Relative Value Units'')

Although the RVUs in the CY 2005 PFS final rule were used to calculate 2005 payment amounts, we considered the RVUs for the new or revised codes to be interim. We accepted comments for a period of 60 days. We received substantive comments for 7 CPT codes with interim work RVUs.

To evaluate these comments, we used a process similar to the process used since 1997. (See the October 31, 1997 final rule (62 FR 59084) for the discussion of refinement of CPT codes with interim work RVUs.) We convened a multispecialty panel of physicians to assist us in the review of the comments. The comments that we did not submit to panel review are discussed at the end of this section, as well as those that were reviewed by the panel, which are contained in Table 28, Codes Reviewed Under the Refinement Process. We invited representatives from the organizations from which we received substantive comments to attend a panel for discussion of the code on which they had commented. The panel was moderated by our medical staff, and consisted of the following voting members:

- One or two clinicians representing the commenting organization.
- One primary care clinician nominated by the American Academy of Family Physicians.
- Three carrier medical directors.
- Two clinicians with practices in related specialties who were expected to have knowledge of the service under review.

The panel discussed the work involved in the procedure under review in comparison to the work associated with other services under the PFS. We assembled a set of 75 reference services and asked the panel members to compare the clinical aspects of the work of the service a commenter believed was incorrectly valued to one or more of the reference services. In compiling the set, we attempted to include: (1) Services that are commonly performed whose work RVUs are not controversial; (2) services that span the entire spectrum from the easiest to the most difficult; and (3) at least three services performed by each of the major specialties so that each specialty would be represented. The intent of the panel process was to capture each participant's independent judgment based on the discussion and his or her clinical experience. Following the discussion, each participant rated the work for the procedure. Ratings were individual and confidential, and there was no attempt to achieve consensus among the panel members.

We then analyzed the ratings based on a presumption that the interim RVUs were correct. To overcome this presumption, the inaccuracy of the interim RVUs had to be apparent to the broad range of physicians participating in each panel.

Ratings of work were analyzed for consistency among the groups represented on each panel. In addition, we used statistical tests to determine whether there was enough agreement among the groups of the panel and whether the agreed-upon RVUs were significantly different from the interim RVUs published in Addendum C of the final rule. We did not modify the RVUs unless there was a clear indication for a change. If there was agreement across groups for change, but the groups did not agree on what the new RVUs should be, we eliminated the outlier group and looked for agreement among the remaining groups as the basis for new RVUs. We used the same methodology in analyzing the ratings that we first used in the refinement process for the 1993 PFS. The statistical tests were described in detail in the November 25, 1992 final rule (57 FR 55938). Our decision to convene multispecialty panels of physicians and to apply the statistical tests we described was based on our need to balance the interests of those who commented on the work RVUs against the redistributive effects that would occur in other specialties.

Table 28 lists those interim codes reviewed under the refinement panel process described in this section. This table includes the following information:

- CPT Code. This is the CPT code for a service.
- Description. This is an abbreviated version of the narrative description of the code.
- 2005 Work RVU. The work RVUs that appeared in the CY 2005 final rule are shown for each reviewed code.
- Requested Work RVU. This column identifies the work RVUs requested by commenters.
- 2006 Work RVU. This column contains the final RVUs for physician work.

TABLE 28.—CODES REVIEWED UNDER THE REFINEMENT PANEL PROCESS

CPT code*	Mod	Descriptor	2005 work RVU	Requested work RVU	2006 work RVU
97605		Neg press wound tx, < 50 cm	Bundled	0.55	0.55
97606		Neg press wound tx, > 50 cm	Bundled	0.60	0.60

*All CPT codes and descriptions copyright 2005 AMA. All rights reserved and applicable FARS/DFARS clauses apply.

2. Interim 2005 Codes

CPT codes 97605 *Negative pressure wound therapy (e.g., vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters and 97606 Negative pressure wound therapy (e.g., vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters.*

The RUC HCPAC review board recommended 0.55 work RVUs for CPT code 97605 and 0.60 work RVUs for CPT code 97606, which we did not accept. We disagreed with their recommendation that these services contained physician work and did not assign work RVUs. Further, when the negative pressure wound therapy service does not encompass selective debridement, we consider the service to represent a dressing change and will not make separate payment. When the negative pressure wound therapy service includes the need for selective debridement, we consider the services represented by CPT codes 97605 and 97606 to be bundled into CPT codes 97597 or 97598. We assigned a status indicator of ''B'' to CPT code 97605 and 97606, meaning that we would not make separate payment for these services.

Comment: Commenters disagreed with our decision not to accept the RUC HCPAC recommended work RVU of 0.55 for CPT code 97605 and 0.60 work RVU for CPT code 97606 and with our decision not to make separate payment for these services. Based on these comments, we referred these codes to the multispecialty validation panel for review.

Response: As a result of the statistical analysis of the 2005 multispecialty validation panel ratings, we have assigned 0.55 work RVUs to CPT code 97605 and 0.60 work RVUs to CPT code 97606.

CPT codes 32855 *Backbench standard preparation of cadaver donor lung allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare pulmonary venous/atrial cuff, pulmonary artery, and bronchus; unilateral;* 32856 *Backbench standard preparation of cadaver donor lung allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare pulmonary venous/atrial cuff, pulmonary artery, and bronchus; bilateral;* 33933 *Backbench standard preparation of cadaver donor heart/lung allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare aorta, superior vena cava, inferior vena cava, and trachea for implantation; Backbench standard preparation of cadaver donor heart allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare aorta, superior vena cava, inferior vena cava, pulmonary artery, and left atrium for implantation;* 44715 *Backbench standard preparation of cadaver or living donor intestine allograft prior to transplantation, including mobilization and fashioning of the superior mesenteric artery and vein;* 47143 *Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary, and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; without trisegment or lobe split;* 47144 *Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary, and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; with trisegment split of whole liver graft into two partial liver grafts (ie, left lateral segment (segments II and III) and right trisegment (segments I and IV through VIII));* 47145 *Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary, and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; with lobe split of whole liver graft into two partial liver grafts (ie, left lobe (segments II, III, and IV) and right lobe (segments I and V through VIII));* 48551 *Backbench standard preparation of cadaver donor pancreas allograft prior to transplantation, including dissection of allograft from surrounding soft tissues, splenectomy, duodenotomy, ligation of bile duct, ligation of mesenteric vessels, and Y-graft arterial anastomoses from iliac artery to superior mesenteric artery and to splenic artery;* 50323 *Backbench standard preparation of cadaver donor renal allograft prior to transplantation, including dissection and removal of perinephric fat, diaphragmatic and retroperitoneal attachments, excision of adrenal gland, and preparation of ureter(s), renal vein(s), and renal artery(s), ligating branches, as necessary; and* 50325 *Backbench standard preparation of living donor renal allograft (open or laparoscopic) prior to transplantation, including dissection and removal of perinephric fat and preparation of ureter(s), renal vein(s), and renal artery(s), ligating branches, as necessary.* These codes, all of which were approved in 2004 for inclusion in the 2005 CPT, were designated by us as carrier-priced.

Comment: Commenters believed these codes describe services which are not payable under the Medicare PFS because they are hospital organ acquisition costs reimbursed under Part A of Medicare. The commenters requested that we change the designation of the standard backbench services from carrier priced to ''excluded by law'', to be consistent with deceased donor procurement codes thereby indicating that they are not included in the definition of physician services for PFS purposes. Commenters also requested that we clarify that these services are included in the definition of hospital organ acquisition costs.

Response: The backbench standard preparation codes describe procedures that are performed by physicians to prepare donor organs for implantation. The procedure is usually performed at the same hospital by the same surgical transplant team where the recipient transplant operation occurs, often in the same or adjacent operating room. It is usually completed shortly prior to or during the recipient transplant operation (especially for the heart and

lung) although more time is available to complete the transplant operations for the liver, kidney, and pancreas. This procedure is a necessary component for completion of the recipient transplant operation. With the exception of living donors, these services are rarely rendered at the hospital where the donor organs are procured. Hospital organ acquisition costs primarily consist of charges for services rendered by the hospital, Organ Procurement Organization (OPO), and the physicians related to retrieving the cadaveric donor organs at the ''donor hospital'' location.

By virtue of its proximate timing and spatial association with the recipient transplant operation, this group of backbench standard preparation procedures are similar to other transplant surgery procedures that are performed by physicians and paid under the Medicare PFS. Therefore, we do not see how they would be considered as hospital organ acquisition costs (as suggested by the commenter). Since the codes for these backbench procedures do not represent deceased donor procurement codes, they would not appropriately be designated as ''excluded by law'' as requested by the commenter. It would be more appropriate to pay for these services under the PFS.

In the specific case of living donors, both the ''donor hospital'' and the ''recipient hospital'' are obviously the same, although both operations are performed simultaneously by different surgical teams. In these cases, the backbench standard preparation procedures may be performed by physician members of either the donor team, the recipient team, or even a third surgical team.

It is recognized that on occasion a donor organ will not be used for transplant at the facility where the backbench standard preparation procedure is performed (often because the intended recipient is found to be medically unsuitable after completion of the backbench work). In these situations, the donor organ may be sent to a different facility for another potential transplant recipient. Even in these situations, the physician performing the backbench procedure has no particular association with the initial donor procurement operation, the OPO, or the ''donor hospital'' site. Therefore, this physician's work is still a physician service that should be paid under the Medicare PFS.

CPT codes 36475 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated* and 36476 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; second and subsequent veins treated in a single extremity, each through separate access sites.* We accepted the RUC recommendation of 6.72 work RVUs for 36475 and 3.38 work RVUs for 36476.

Comment: We received a comment expressing concerns that we assigned endovenous radiofrequency (RF) ablation procedures (CPT code 36475 and 36476) the same work RVUs as were assigned to endovenous laser procedures (CPT codes 36478 and 36479). The commenter strongly urged us to reevaluate the work RVUs for RF ablation procedures. The commenter also noted that the vignette developed for the RF procedure was used for the laser procedure with one modification—the word radiofrequency was changed to ''laser'' and as a result, the vignette for the laser procedure was inaccurate, misleading, and created the impression that the work for the laser procedure is as intense as the work for the RF procedure. The commenter believed the mistaken description likely blurred the distinctions between the two procedures in terms of work and procedure time. The commenter also believed the flawed survey is evidence that the work RVUs for RF procedures were not appropriate and should be reexamined.

Response: We believe the RUC appropriately valued these codes based upon the information that was provided to them during the RUC survey process and suggest the commenter contact the specialty society to have these codes reexamined by the RUC.

In the CY 2005 final rule (69 FR 66370), we also responded to the RUC recommendations on the PE inputs for the new and revised CPT codes for 2005. Comments received on the PE inputs were addressed earlier in this preamble in the PE proposals for CY 2006 with the exception of comments received on CPT codes 36475 and 36476. As noted in the previous discussion concerning refinement of interim work RVUs, the commenter indicated the vignette was incorrect and therefore we believe the concerns about PE should also be handled through the RUC process by the specialty society.

D. Establishment of Interim Work Relative Value Units for New and Revised Physician's Current Procedural Terminology (CPT) Codes and New Healthcare Common Procedure Coding System Codes (HCPCS) for 2006 (Includes Table titled ''American Medical Association Specialty Relative Value Update Committee and Health Care Professionals Advisory Committee Recommendations and CMS's Decisions for New and Revised 2006 CPT Codes'')

One aspect of establishing RVUs for 2006 was to assign interim work RVUs for all new and revised CPT codes. As described in our November 25, 1992 notice on the 1993 PFS (57 FR 55951) and in section III.B. of the November 22, 1996 final rule (61 FR 59505), we established a process, based on recommendations received from the AMA's RUC, for establishing interim work RVUs for new and revised codes.

This year we received work RVU recommendations for 175 new and revised CPT codes from the RUC. Our staff and medical officers reviewed the RUC recommendations by comparing them to our reference set or to other comparable services for which work RVUs had previously been established. We also considered the relationships among the new and revised codes for which we received RUC recommendations and agreed with the majority of the relative relationships reflected in the RUC values. In some instances, although we agreed with the relationships, we nonetheless revised the work RVUs to achieve work neutrality within families of codes. That is, the work RVUs were adjusted so that the sum of the new or revised work RVUs (weighted by projected frequency of use) for a family will be the same as the sum of the current work RVUs (weighted by projected frequency of use) for the family of codes. We reviewed all the RUC recommendations and accepted approximately 94 percent of the RUC recommended values. For approximately 6 percent of the recommendations, we agreed with the relativity established by the RUC, but needed to adjust work RVUs to retain budget neutrality.

We received 9 recommendations from the Health Care Professional Advisory Committee (HCPAC). We agreed with seven of these recommendations and disagreed with two of them.

Table 29, titled ''AMA RUC and HCPAC Recommendations and CMS Decisions for New and Revised 2006 CPT Codes,'' lists the new or revised CPT codes, and their associated work RVUs, that will be interim in 2006. This

table includes the following information:

- A ''#'' identifies a new code for 2006.
- CPT code. This is the CPT code for a service.
- Modifier. A ''26'' in this column indicates that the work RVUs are for the professional component of the code.
- Description. This is an abbreviated version of the narrative description of the code.
- RUC recommendations. This column identifies the work RVUs recommended by the RUC.
- HCPAC recommendations. This column identifies the work RVUs recommended by the HCPAC.
- CMS decision. This column indicates whether we agreed or we disagreed with the RUC recommendation. Codes for which we did not accept the RUC recommendation are discussed in greater detail following this table. An ''(a)'' indicates that no RUC recommendation was provided.
- 2006 Work RVUs. This column establishes the interim 2006 work RVUs for physician work.

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TABLE 29: AMA RUC and HCPAC Recommendations and CMS Decisions for New and Revised 2006 CPT Codes

*CPT Code	Mod	Short Descriptor	RUC recommendation	HCPAC recommendation	CMS Decision	2006 work RVU
#15040		HARVEST CULTURED SKIN GRAFT	2.00	----------	Agree	2.00
#15110		EPIDRM AUTOGRFT TRNK/ARM/LEG	9.50	----------	Agree	9.50
#15111		EPIDRM AUTOGRFT T/A/L ADD-ON	1.85	----------	Agree	1.85
#15115		EPIDRM A-GRFT FACE/NCK/HF/G	9.81	----------	Agree	9.81
#15116		EPIDRM A-GRFT F/N/HF/G ADDL	2.50	----------	Agree	2.50
#15130		DERM AUTOGRAFT, TRNK/ARM/LEG	7.00	----------	Agree	7.00
#15131		DERM AUTOGRAFT T/A/L ADD-ON	1.50	----------	Agree	1.50
#15135		DERM AUTOGRAFT FACE/NCK/HF/G	10.50	----------	Agree	10.50
#15136		DERM AUTOGRAFT, F/N/HF/G ADD	1.50	----------	Agree	1.50
#15150		CULT EPIDERM GRFT T/ARM/LEG	8.25	----------	Agree	8.25
#15151		CULT EPIDERM GRFT T/A/L ADDL	2.00	----------	Agree	2.00
#15152		CULT EPIDERM GRAFT T/A/L +%	2.50	----------	Agree	2.50
#15155		CULT EPIDERM GRAFT, F/N/HF/G	9.00	----------	Agree	9.00
#15156		CULT EPIDRM GRFT F/N/HFG ADD	2.75	----------	Agree	2.75
#15157		CULT EPIDERM GRFT F/N/HFG +%	3.00	----------	Agree	3.00
#15170		ACELL GRAFT TRUNK/ARMS/LEGS	5.00	----------	Agree	5.00
#15171		ACELL GRAFT T/ARM/LEG ADD-ON	1.55	----------	Agree	1.55
#15175		ACELLULAR GRAFT, F/N/HF/G	7.00	----------	Agree	7.00
#15176		ACELL GRAFT, F/N/HF/G ADD-ON	2.45	----------	Agree	2.45
#15300		APPLY SKINALLOGRFT, T/ARM/LG	3.99	----------	Agree	3.99
#15301		APPLY SKNALLOGRFT T/A/L ADDL	1.00	----------	Agree	1.00
#15320		APPLY SKIN ALLOGRFT F/N/HF/G	4.70	----------	Agree	4.70
#15321		APLY SKNALLOGRFT F/N/HFG ADD	1.50	----------	Agree	1.50
#15330		APLY ACELL ALOGRFT T/ARM/LEG	3.99	----------	Agree	3.99
#15331		APLY ACELL GRFT T/A/L ADD-ON	1.00	----------	Agree	1.00
#15335		APPLY ACELL GRAFT, F/N/HF/G	4.50	----------	Agree	4.50
#15336		APLY ACELL GRFT F/N/HF/G ADD	1.43	----------	Agree	1.43
#15340		APPLY CULT SKIN SUBSTITUTE	3.72	----------	Agree	3.72
#15341		APPLY CULT SKIN SUB ADD-ON	0.50	----------	Agree	0.50
#15360		APPLY CULT DERM SUB, T/A/L	3.87	----------	Agree	3.87
#15361		APLY CULT DERM SUB T/A/L ADD	1.15	----------	Agree	1.15
#15365		APPLY CULT DERM SUB F/N/HF/G	4.15	----------	Agree	4.15
#15366		APPLY CULT DERM F/HF/G ADD	1.45	----------	Agree	1.45
#15420		APPLY SKIN XGRAFT, F/N/HF/G	4.50	----------	Agree	4.50
#15421		APPLY SKN XGRFT F/N/HF/G ADD	1.50	----------	Agree	1.50
#15430		APPLY ACELLULAR XENOGRAFT	5.75	----------	Agree	5.75
#15431		APPLY ACELLULAR XGRAFT ADD	Carrier	----------	Agree	Carrier
#22010		I&D, P-SPINE, C/T/CERV-THOR	11.05	----------	Agree	11.05
#22015		I&D, P-SPINE, L/S/LS	10.94	----------	Agree	10.94
#22523		PERCUT KYPHOPLASTY, THOR	8.94	----------	Agree	8.94
#22524		PERCUT KYPHOPLASTY, LUMBAR	8.54	----------	Agree	8.54
#22525		PERCUT KYPHOPLASTY, ADD-ON	4.47	----------	Agree	4.47
#28890		HIGH ENERGY ESWT, PLANTAR F	3.30	----------	Agree	3.30
#32503		RESECT APICAL LUNG TUMOR	30.00	----------	Agree	30.00
#32504		RESECT APICAL LUNG TUM/CHEST	34.80	----------	Agree	34.80
#33507		REPAIR ART, INTRAMURAL	30.00	----------	Agree	30.00
#33548		RESTORE/REMODEL, VENTRICLE	37.97	----------	Agree	37.97
#33768		CAVOPULMONARY SHUNTING	8.00	----------	Agree	8.00
#33880		ENDOVASC TAA REPR INCL SUBCL	33.00	----------	Agree	33.00
#33881		ENDOVASC TAA REPR W/O SUBCL	28.00	----------	Agree	28.00
#33883		INSERT ENDOVASC PROSTH, TAA	20.00	----------	Agree	20.00
#33884		ENDOVASC PROSTH, TAA, ADD-ON	8.20	----------	Agree	8.20
#33886		ENDOVASC PROSTH, DELAYED	17.00	----------	Agree	17.00
#33889		ARTERY TRANSPOSE/ENDOVAS TAA	15.92	----------	Agree	15.92

*CPT Code	Mod	Short Descriptor	RUC recommendation	HCPAC recommendation	CMS Decision	2006 work RVU
#33891		CAR-CAR BP GRFT/ENDOVAS TAA	20.00	----------	Agree	20.00
#33925		RPR PUL ART UNIFOCAL W/O CPB	29.50	----------	Agree	29.50
#33926		REPR PUL ART, UNIFOCAL W/CPB	42.00	----------	Agree	42.00
#36598		INJ W/FLUOR, EVAL CV DEVICE	0.74	----------	Agree	0.74
#37184		PRIM ART MECH THROMBECTOMY	8.66	----------	Agree	8.66
#37185		PRIM ART M-THROMBECT ADD-ON	3.28	----------	Agree	3.28
#37186		SEC ART M-THROMBECT ADD-ON	4.92	----------	Agree	4.92
#37187		VENOUS MECH THROMBECTOMY	8.03	----------	Agree	8.03
#37188		VENOUS M-THROMBECTOMY ADD-ON	5.71	----------	Agree	5.71
#37718		LIGATE/STRIP SHORT LEG VEIN	6.76	----------	Agree	6.76
#37722		LIGATE/STRIP LONG LEG VEIN	7.79	----------	Agree	7.79
#43770		LAP, PLACE GASTR ADJUST BAND	16.71	----------	Agree	16.71
#43771		LAP, REVISE ADJUST GAST BAND	19.50	----------	Agree	19.50
#43772		LAP, REMOVE ADJUST GAST BAND	15.00	----------	Agree	15.00
#43773		LAP, CHANGE ADJUST GAST BAND	19.50	----------	Agree	19.50
#43774		LAP REMOV ADJ GAST BAND/PORT	15.00	----------	Agree	15.00
43845		GASTROPLASTY DUODENAL SWITCH	31.00	----------	Agree	31.00
#43886		REVISE GASTRIC PORT, OPEN	4.00	----------	Agree	4.00
#43887		REMOVE GASTRIC PORT, OPEN	3.95	----------	Agree	3.95
#43888		CHANGE GASTRIC PORT, OPEN	5.80	----------	Agree	5.80
#44180		LAP, ENTEROLYSIS	14.42	----------	Agree	14.42
#44186		LAP, JEJUNOSTOMY	9.77	----------	Agree	9.77
#44187		LAP, ILEO/JEJUNO-STOMY	15.93	----------	Agree	15.93
#44188		LAP, COLOSTOMY	17.61	----------	Agree	17.61
#44213		LAP, MOBIL SPLENIC FL ADD-ON	3.50	----------	Agree	3.50
#44227		LAP, CLOSE ENTEROSTOMY	26.50	----------	Agree	26.50
#45395		LAP, REMOVAL OF RECTUM	30.50	----------	Agree	30.50
#45397		LAP, REMOVE RECTUM W/POUCH	34.00	----------	Agree	34.00
#45400		LAPAROSCOPIC PROCTOPEXY	18.06	----------	Agree	18.06
#45402		LAP PROCTOPEXY W/SIG RESECT	25.04	----------	Agree	25.04
#45499		LAPAROSCOPE PROC, RECTUM	Carrier	----------	Agree	Carrier
#45990		SURG DX EXAM, ANORECTAL	1.80	----------	Agree	1.80
#46505		CHEMODENERVATION ANAL MUSC	2.86	----------	Agree	2.86
#46710		REPR PER/VAG POUCH SNGL PROC	16.00	----------	Agree	16.00
#46712		REPR PER/VAG POUCH DBL PROC	34.00	----------	Agree	34.00
#50250		CRYOABLATE RENAL MASS OPEN	19.97	----------	Agree	19.97
#50382		CHANGE URETER STENT, PERCUT	5.50	----------	Agree	5.50
#50384		REMOVE URETER STENT, PERCUT	5.00	----------	Agree	5.00
#50387		CHANGE EXT/INT URETER STENT	2.00	----------	Agree	2.00
#50389		REMOVE RENAL TUBE W/FLUORO	1.10	----------	Agree	1.10
#50592		PERC RF ABLATE RENAL TUMOR	6.75	----------	Agree	6.75
#51999		LAPAROSCOPE PROC, BLADDER	Carrier	----------	Agree	Carrier
#57295		CHANGE VAGINAL GRAFT	7.45	----------	Agree	7.45
#58110		BX DONE W/COLPOSCOPY ADD-ON	0.77	----------	Agree	0.77
#64650		CHEMODENERV ECCRINE GLANDS	0.70	----------	Agree	0.70
#64653		CHEMODENERV ECCRINE GLANDS	0.88	----------	Agree	0.88

*CPT Code	Mod	Short Descriptor	RUC recommendation	HCPAC recommendation	CMS Decision	2006 work RVU
67901		REPAIR EYELID DEFECT	7.39	----------	Agree	7.39
67902		REPAIR EYELID DEFECT	9.35	----------	Agree	9.35
#75956	26	XRAY, ENDOVASC THOR AO REPR	7.00	----------	Agree	7.00
#75957	26	XRAY, ENDOVASC THOR AO REPR	6.00	----------	Agree	6.00
#75958	26	XRAY, PLACE PROX EXT THOR AO	4.00	----------	Agree	4.00
#75959	26	XRAY, PLACE DIST EXT THOR AO	3.50	----------	Agree	3.50
#76376	26	3D RENDER W/O POSTPROCESS	0.20	----------	Agree	0.20
#76377	26	3D RENDERING W/POSTPROCESS	0.79	----------	Agree	0.79
#77421	26	STEREOSCOPIC X-RAY GUIDANCE	0.39	----------	Agree	0.39
#77422		NEUTRON BEAM TX, SIMPLE	0.00	----------	Agree	0.00
#77423		NEUTRON BEAM TX, COMPLEX	0.00	----------	Agree	0.00
#88333		INTRAOP CYTO PATH CONSULT, 1	1.20	----------	Agree	1.20
#88334		INTRAOP CYTO PATH CONSULT, 2	0.80	----------	Disagree	0.59
#88384		EVAL MOLECULAR PROBES, 11-50	Carrier	----------	Agree	Carrier
#88385	26	EVAL MOLECUL PROBES, 51-250	1.50	----------	Agree	1.50
#88386	26	EVAL MOLECUL PROBES, 251-500	1.88	----------	Agree	1.88
#89049		CHCT FOR MAL HYPERTHERMIA	1.40	----------	Agree	1.40
#90760		HYDRATION IV INFUSION, INIT	0.17	----------	Agree	0.17
#90761		HYDRATE IV INFUSION, ADD-ON	0.09	----------	Agree	0.09
#90765		THER/PROPH/DIAG IV INF, INIT	0.21	----------	Agree	0.21
#90766		THER/PROPH/DG IV INF, ADD-ON	0.18	----------	Agree	0.18
#90767		TX/PROPH/DG ADDL SEQ IV INF	0.19	----------	Agree	0.19
#90768		THER/DIAG CONCURRENT INF	0.17	----------	Agree	0.17
#90772		THER/PROPH/DIAG INJ, SC/IM	0.17	----------	Agree	0.17
#90773		THER/PROPH/DIAG INJ, IA	(a)	----------	(a)	0.17
#90774		THER/PROPH/DIAG INJ, IV PUSH	0.18	----------	Agree	0.18
#90775		THER/PROPH/DIAG INJ ADD-ON	0.10	----------	Agree	0.10
#90779		THER/PROP/DIAG INJ/INF PROC	Carrier	----------	Agree	Carrier
#91022	26	DUODENAL MOTILITY STUDY	1.44	----------	Agree	1.44
92520		LARYNGEAL FUNCTION STUDIES	0.75	----------	Agree	0.75
#92626		EVAL AUD REHAB STATUS	----------	0.00	Agree	0.00
#92627		EVAL AUD STATUS REHAB ADD-ON	----------	0.00	Agree	0.00
#95251		GLUC MONITOR, CONT, PHYS I&R	0.85	----------	Disagree	0.52
#95865	26	MUSCLE TEST, LARYNX	1.57	----------	Agree	1.57
#95866	26	MUSCLE TEST, HEMIDIAPHRAGM	1.25	----------	Agree	1.25
#95873	26	GUIDE NERV DESTR, ELEC STIM	0.56	----------	Disagree	0.37
#95874	26	GUIDE NERV DESTR, NEEDLE EMG	0.56	----------	Disagree	0.37
#96101		PSYCHO TESTING BY PSYCH/PHYS	----------	1.86	Agree	1.86
#96102		PSYCHO TESTING BY TECHNICIAN	----------	0.50	Agree	0.50
#96103		PSYCHO TESTING ADMIN BY COMP	----------	0.51	Agree	0.51
#96116		NEUROBEHAVIORAL STATUS EXAM	----------	2.05	Disagree	1.86
#96118		NEUROPSYCH TST BY PSYCH/PHYS	----------	2.05	Disagree	1.86
#96119		NEUROPSYCH TESTING BY TECH	----------	0.55	Agree	0.55
#96120		NEUROPSYCH TST ADMIN W/COMP	----------	0.51	Agree	0.51
#96401		CHEMO, ANTI-NEOPL, SQ/IM	0.21	----------	Agree	0.21
#96402		CHEMO HORMON ANTINEOPL SQ/IM	0.19	----------	Agree	0.19

*CPT Code	Mod	Short Descriptor	RUC recommendation	HCPAC recommendation	CMS Decision	2006 work RVU
#96409		CHEMO, IV PUSH, SNGL DRUG	0.24	----------	Agree	0.24
#96411		CHEMO, IV PUSH, ADDL DRUG	0.20	----------	Agree	0.20
#96413		CHEMO, IV INFUSION, 1 HR	0.28	----------	Agree	0.28
#96415		CHEMO, IV INFUSION, ADDL HR	0.19	----------	Agree	0.19
#96416		CHEMO PROLONG INFUSE W/PUMP	0.21	----------	Agree	0.21
#96417		CHEMO IV INFUS EACH ADDL SEQ	0.21	----------	Agree	0.21
96450		CHEMOTHERAPY, INTO CNS	1.53	----------	Agree	1.53
#96521		REFILL/MAINT, PORTABLE PUMP	0.21	----------	Agree	0.21
#96522		REFILL/MAINT PUMP/RESVR SYST	0.21	----------	Agree	0.21
#96523		IRRIG DRUG DELIVERY DEVICE	0.04	----------	Agree	0.04
96542		CHEMOTHERAPY INJECTION	0.75	----------	Agree	0.75
#97760		ORTHOTIC MGMT AND TRAINING	0.45	----------	Agree	0.45
#97761		PROSTHETIC TRAINING	0.45	----------	Agree	0.45
#97762		C/O FOR ORTHOTIC/PROSTH USE	0.25	----------	Agree	0.25
#99143		MOD CS BY SAME PHYS, < 5 YRS	0.70	----------	Disagree	Carrier
#99144		MOD CS BY SAME PHYS, 5 YRS +	0.66	----------	Disagree	Carrier
#99145		MOD CS BY SAME PHYS ADD-ON	0.23	----------	Disagree	Carrier
#99148		MOD CS DIFF PHYS < 5 YRS	1.75	----------	Disagree	Carrier
#99149		MOD CS DIFF PHYS 5 YRS +	1.64	----------	Disagree	Carrier
#99150		MOD CS DIFF PHYS ADD-ON	0.47	----------	Disagree	Carrier
#99300		IC, INFANT PBW 2501-5000 GM	2.40	----------	Agree	2.40
#99304		NURSING FACILITY CARE, INIT	1.20	----------	Agree	1.20
#99305		NURSING FACILITY CARE, INIT	1.61	----------	Agree	1.61
#99306		NURSING FACILITY CARE, INIT	2.01	----------	Agree	2.01
#99307		NURSING FAC CARE, SUBSEQ	0.60	----------	Agree	0.60
#99308		NURSING FAC CARE, SUBSEQ	1.00	----------	Agree	1.00
#99309		NURSING FAC CARE, SUBSEQ	1.42	----------	Agree	1.42
#99310		NURSING FAC CARE, SUBSEQ	1.77	----------	Agree	1.77
#99318		ANNUAL NURSING FAC ASSESSMNT	1.20	----------	Agree	1.20
#99324		DOMICIL/R-HOME VISIT NEW PAT	1.01	----------	Agree	1.01
#99325		DOMICIL/R-HOME VISIT NEW PAT	1.52	----------	Agree	1.52
#99326		DOMICIL/R-HOME VISIT NEW PAT	2.27	----------	Agree	2.27
#99327		DOMICIL/R-HOME VISIT NEW PAT	3.03	----------	Agree	3.03
#99328		DOMICIL/R-HOME VISIT NEW PAT	3.78	----------	Agree	3.78
#99334		DOMICIL/R-HOME VISIT EST PAT	0.76	----------	Agree	0.76
#99335		DOMICIL/R-HOME VISIT EST PAT	1.26	----------	Agree	1.26
#99336		DOMICIL/R-HOME VISIT EST PAT	2.02	----------	Agree	2.02
#99337		DOMICIL/R-HOME VISIT EST PAT	3.03	----------	Agree	3.03

(a) No Final RUC recommendation provided
New CPT code
* All CPT codes copyright 2005 AMA

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Table 30, which is titled ''AMA RUC ANESTHESIA RECOMMENDATIONS AND CMS DECISIONS FOR NEW AND REVISED 2006 CPT CODES'', lists the new or revised CPT codes for anesthesia and their base units that will be interim in 2006. This table includes the following information:

- CPT code. This is the CPT code for a service.
- Description. This is an abbreviated version of the narrative description of the code.
- RUC recommendations. This column identifies the base units recommended by the RUC.
- CMS decision. This column indicates whether we agreed or we disagreed with the RUC recommendation. Codes for which we did not accept the RUC recommendation are discussed in greater detail following this table.
- 2006 Base Units. This column establishes the 2006 base units for these services.

TABLE 30.—AMA RUC ANESTHESIA RECOMMENDATIONS AND CMS DECISIONS FOR NEW AND REVISED CPT CODES

*CPT CODE	Description	RUC recommendation	CMS decision	2006 base units
#01965	ANESTH, INC/MISSED AB PROC	4.00	Agree	4.00
#01966	ANESTH, INDUCED AB PROCEDURE	4.00	Agree	4.00

* All CPT codes copyright 2005 AMA.
# New CPT code.

E. Discussion of Codes for Which There Were No RUC Recommendations or for Which the RUC Recommendations Were Not Accepted

The following is a summary of our rationale for not accepting particular RUC work RVUs, base unit recommendations, or for accepting RUC recommendations with an intention to continue to monitor and reexamine the code(s) in the near future. It is arranged by type of service in CPT order. This summary refers only to work RVUs or Base Units.

New and Revised Codes for 2006

CPT codes 61630 *Balloon angioplasty, intracranial (e.g., atherosclerotic stenosis), percutaneous;* 61635 *Transcatheter placement of intravascular stent(s), intracranial (e.g., athersosclerotic stenosis), including balloon angioplasty if performed;* 61640 *Balloon dilatation of intracranial vasospasm, percutaneous, initial vessel;* 61641 *Balloon dilatation of intracranial vasospasm, percutaneous, initial vessel; each additional vessel in same vascular family;* and 61642 *Balloon dilatation of intracranial vasospasm, percutaneous, initial vessel; each additional vessel in different vascular family.*—The RUC recommended 21.08 work RVUs for 61630, 23.08 work RVUs for 61635, 12.32 work RVUs for 61640, 4.33 work RVUs for 61641 and 8.66 work RVUs for 61642. We are assigning a status indicator of N for these services because they are noncovered under Medicare due to a National Coverage Decision.

CPT codes 76376 *3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality; not requiring image post-processing on an independent workstation* and 76377 *3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality; requiring image post processing on an independent workstation.*—The CPT Editorial Panel created CPT codes 76376 and 76377 to describe the new technology of volumetric acquisition of advanced cross-sectional imaging. The RUC recommended 0.20 work RVUs for CPT code 76376 and 0.79 work RVUs for CPT code 76377. These services were previously reported using CPT code 76375 *Coronal, sagittal, multiplanar, oblique, 3-dimensional and/or holographic reconstruction of computed tomography, magnetic resonance imaging, or other tomography modality.*—According to the specialty society of the services reported for 76375, 80 to 90 percent reflected two-dimensional multiplanar reformatting and only 10 to 20 percent reflected three-dimensional rendering described in codes 76376 and 76377. Although we are accepting the utilization crosswalks recommended by the specialty society and the work RVUs recommended by the RUC, we will continue to evaluate the work and utilization associated with these services over the next year and reexamine these codes in the future.

CPT code 88334 *Pathology consultation during surgery; cytologic examination (e.g., touch prep, squash prep), each additional site.*—The RUC recommended a work RVU of 0.80 for this service based on a comparison of this procedure to CPT code 88332 *Pathology consultation during surgery; each additional tissue block, with frozen section(s).* The RUC reviewed the specialty society's survey data and noted that the surveyed code 88334, when compared to the reference code 88332 has higher intensity/complexity measures and an additional five minutes of intra-service time, 20 minutes and 15 minutes, respectively. Although 88334 has an additional five minutes of intra-service time, we believe that 88334 is very similar in work to 88332 and, therefore, should be valued the same. We have assigned 0.59 work RVUs to 88334.

CPT codes 88384 *Array-based evaluation of multiple molecular probes; 11 through 50 probes,* 88385 *Array-based evaluation of multiple molecular probes; 51 through 250 probes* and 88386 *Array-based evaluation of multiple molecular probes; 251 through 500 probes.*—The RUC recommended that the base code (88384) be carrier priced and recommended 1.50 work RVUs for 88385 and 1.88 work RVUs for 88386. We will allow the base code to be carrier priced and are accepting the RUC recommended values for 88385 and 88386. We will continue to evaluate the work and utilization associated with all of these services over the next year and reexamine these codes in the future.

CPT code 90773 *Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intra-arterial.*—We did not receive a final RUC recommendation for this code. This code replaces CPT code 90783 *Therapeutic, prophylactic or diagnostic injection (specify material injected); intra-arterial,* which has been deleted and was assigned 0.17 work RVUs. On an interim basis, we have assigned 0.17 work RVUs to 90773 since it replaces 90783.

CPT code 92630 *Auditory rehabilitation, pre-lingual hearing loss* and 92633 *Auditory rehabilitation, post-lingual hearing loss.*—CPT codes 92630 and 92633 represent speech language pathology and audiology services. These CPT codes describe rehabilitative or therapeutic services. When speech-language pathologists (SLPs) provide these services, they may bill for them by using CPT code 92507 *Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual,* as appropriate. According to the Medicare statute, section 1861(ll)(2) of the Act, audiologists are recognized for purposes of providing diagnostic testing services to Medicare beneficiaries. Therefore, we will not recognize CPT codes 92630 and 92633 under Medicare and have assigned a status indicator of I because these services represent therapeutic services rather than diagnostic tests.

CPT code 95251 *Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for up to 72 hours; physician interpretation and report.*—The RUC recommended a work RVU of 0.85 for this service. We disagree with the RUC's recommendation because we believe the work for this service is similar to CPT code 93268 *Patient demand single or multiple event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; includes*

transmission, physician review and interpretation, which involves the review of data over a 30 day period. Therefore, we have assigned 0.52 work RVUs to 95251.

CPT codes 95873 *Electrical stimulation for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure) and 95874 (Needle electromyography for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure).*—The RUC recommended a work RVU of 0.56 for CPT codes 95873 and 95874. The RUC examined reference code 95860 *(Needle electromyography; one extremity with or without related paraspinal areas)* and determined that the intensity for the new procedures and the reference procedure were the same so a proper value for both new codes should be based on the ratio of time with the reference code. We believe that the work involved with 95873 and 95874 is very similar to 95870 and therefore should be valued the same. We have assigned 0.37 work RVUs to CPT codes 95873 and 95874.

CPT codes 96116 *Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities); per hour of the psychologist's or physician's time, both face-to-face time with the patient and time preparing the report and 96118 Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test); per hour of the psychologist's or physician's time, both face-to-face time with the patient and time preparing the report.*—The HCPAC recommended 2.05 work RVUs for CPT codes 96116 and 96118. We disagree with the HCPAC's recommendation and believe the physician work associated with these services is similar to 96101, as reflected by the technical skill, judgment and complexity of these services. Therefore, we have assigned 1.86 work RVUs to 96116 and 96118.

CPT codes 98960 *Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient;* 98961 *Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2–4 patients;* and 98962 *Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5–8 patients.*—We are assigning a status indicator of N for these services because they are noncovered under Medicare.

CPT codes 99143 *Moderate sedation services (other than those services described by codes 00100–01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status, under 5 years of age; first 30 minutes intra-service time,* 99144 *Moderate sedation services (other than those services described by codes 00100–01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status, age 5 years or older; first 30 minutes intra-service time,* 99145 *Moderate sedation services (other than those services described by codes 00100–01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status, age 5 years or older; each additional 15 minutes intra-service time,* 99148 *Moderate sedation services (other than those services described by codes 00100–01999) provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports, under 5 years of age; first 30 minutes intra-service time,* 99149 *Moderate sedation services (other than those services described by codes 00100–01999) provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports, age 5 years or older; first 30 minutes intra-service time,* 99150 *Moderate sedation services (other than those services described by codes 00100–01999) provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports, each additional 15 minutes intra-service time.*—The CPT Editorial Panel created six new codes to accurately report 2 separate families of moderate sedation. One family describes the provision of moderate sedation services by the physician who is performing the diagnostic or therapeutic service and supervising an independent trained observer while the other family describes moderate sedation services performed by a physician (other than an anesthesiologist) other than the physician performing a diagnostic or therapeutic service. These new codes replace CPT codes 99141 *Sedation with or without analgesia (conscious sedation); intravenous, intra-muscular or inhalation* and 99142 *Sedation with or without analgesia (conscious sedation); oral, rectal and/or intranasal,* which were bundled under the PFS. The RUC recommended 0.70 work RVUs for 99143, 0.66 work RVUs for 99144, 0.23 work RVUs for 99145, 1.75 work RVUs for 99148, 1.65 work RVUs for 99149 and 0.47 work RVUs for 99150. We are uncertain whether the RUC assigned values are appropriate and have carrier priced these codes in order to gather information for utilization and proper pricing.

F. Establishment of Interim PE RVUs for New and Revised Physician's Current Procedural Terminology (CPT) Codes and New Healthcare Common Procedure Coding System (HCPCS) Codes for 2006.

We have developed a process for establishing interim PE RVUs for new and revised codes that is similar to that used for work RVUs. Under this process, the RUC recommends the PE direct inputs (the staff time, supplies and equipment) associated with each new code. We then review the recommendations in a manner similar to our evaluation of the recommended work RVUs. The RUC recommendations on the PE inputs for the new and revised 2006 codes were submitted to us as interim recommendations.

We have accepted, in the interim, the PE recommendations submitted by the RUC for the codes listed in the table titled ''AMA RUC and HCPAC RVU Recommendations and CMS Decisions for New and Revised 2006 CPT Codes.''

CPT code 28890 *Extracorporeal shock wave, high energy, performed by a physician, requiring anesthesia other than local, including ultrasound guidance, involving the plantar fascia.*—We accepted the work RVUs for CPT 28890. However, we disagree with the RUC's recommendation to value this procedure only in the facility setting. We believe that this procedure is being performed in the nonfacility setting and are assigning the following PE inputs based on information that the RUC

provided for informational purposes: (a) Total clinical labor time of 133 minutes consisting of 16 minutes for pre-service, 36 minutes for the service period, and 81 minutes for the post-service period; (b) supplies consist of 4 multispecialty supply packages (1 each for the procedure and each of the 3 post visits), 1 fenestrated drape, 3 18–24 gauge needles, 1 10cc syringe, 5cc of lidocaine 1 percent, 5cc of marcaine 0.5 percent, and 2 alcohol swabs; and (c) equipment includes ESW machine used for the procedure for 36 minutes and a power table and an exam lamp each for 117 minutes (includes the 36 minute procedure and 81 minutes for the post visits).

CPT 89049 *Caffeine halothane contracture test (CHCT) for malignant hyperthermia susceptibility, including interpretation and report.*—While we accepted the work RVUs for this procedure, we disagreed with a PE recommendation regarding 30 minutes clinical labor—provided by a staff blend comprised of a combination laboratory technician and histotechnologist—that was requested to prepare the registry report. Because we do not pay for the clinical labor necessary to prepare registry reports in any other procedure codes, we have deleted the 30 minutes report preparation time from the total service period time in the practice labor expense database. The net result for the clinical labor service period is 274 minutes for CPT 89049.

IV. Five-Year Refinement of RVUs—Status Update

In the CY 2005 final rule (69 FR 66236), we solicited comments on the work RVUs that may be inappropriately valued. Since we recognized that this process generally elicits comments focusing on undervalued codes, we also indicated that we would identify codes (especially high-volume codes across specialties) that:

- Are valued as being performed in the inpatient setting, but that are now predominantly performed on an outpatient basis; and
- Were not reviewed by the RUC, (that is, Harvard RVUs are still being used, or there is no information).

We received comments on potentially misvalued services from approximately 35 specialty organizations and individuals involving over 500 codes. We shared these comments with the RUC and also identified approximately 160 additional codes for review. As explained in the CY 2005 final rule (69 FR 66236), we proposed to utilize a process similar to that established for the assignment of RVUs for new and revised CPT codes where the RUC makes recommendations on work RVUs for services. This process was used during the last 5-year review, and we believe that it was beneficial. The RUC's perspective is helpful because of its experience in recommending RVUs for new and revised CPT codes since we implemented the PFS. Furthermore, the RUC, by virtue of its multispecialty membership and consultation with approximately 65 specialty societies, involves the medical community in the refinement process.

We will consider all comments on all work RVUs in the development of a proposed rule that we will publish 2006. In that rule, we will propose the revisions to work RVUs that we believe are needed. We will then review and analyze the comments received in response to our proposed revisions and publish our decisions in the final rule for CY 2007.

V. Physician Self-Referral Prohibition: Nuclear Medicine and Annual Update to the List of CPT/HCPCS Codes

A. General

Section 1877 of the Act prohibits a physician from referring a Medicare beneficiary for certain designated health services (DHS) to a health care entity with which the physician (or a member of the physician's immediate family) has a financial relationship, unless an exception applies. Section 1877 of the Act also prohibits the DHS entity from submitting claims to Medicare or billing the beneficiary or any other entity for Medicare DHS that are furnished as a result of a prohibited referral.

As specified in our regulations at § 411.351, the following services are DHS:

- Clinical laboratory services.
- Physical therapy, occupational therapy, and speech-language pathology services.
- Radiology and certain other imaging services.
- Radiation therapy services and supplies.
- Durable medical equipment and supplies.
- Parenteral and enteral nutrients, equipment, and supplies.
- Prosthetics, orthotics, and prosthetic devices and supplies.
- Home health services.
- Outpatient prescription drugs.
- Inpatient and outpatient hospital services.

B. Nuclear Medicine

In the August 8, 2005 rule, we proposed to include diagnostic and therapeutic nuclear medicine procedures under the DHS categories for radiology and certain other imaging services and radiation therapy services and supplies, respectively. The DHS categories of radiology and certain other imaging services and radiation therapy services and supplies are defined by a list of CPT and HCPCS codes that is updated annually and posted on our web site. In the August 8, 2005 proposed rule (70 FR 45764), we stated that we would revise the list of CPT and HCPCS codes (List of CPT/HCPCS Codes) that identifies the items and services that are included in each of these DHS categories. Addendum G of the proposed rule set forth a list of codes for all diagnostic nuclear medicine procedures, all therapeutic nuclear medicine procedures, and the radiopharmaceuticals used in diagnostic and therapeutic nuclear medicine procedures. Additionally, we stated our intention to include diagnostic nuclear medicine services on the revised List of CPT/HCPCS Codes under ''Radiology and Certain Other Imaging Services'' and to include therapeutic nuclear medicine services on the revised List of CPT/HCPCS Codes under ''Radiation Therapy Services and Supplies''. We stated that some radiopharmaceuticals may be included in both categories.

We requested comments concerning whether the list was accurate and complete. In addition, we requested comments as to whether, or how, to minimize the impact on physicians who are currently parties to arrangements that involve nuclear medicine services and supplies (that is, by specifying a delayed effective date or by grandfathering certain arrangements).

1. Response to Comments

We received many comments in response to our proposal to add diagnostic and therapeutic nuclear medicine services and supplies to the list of designated health services subject to the physician self-referral prohibition. Comments were submitted by or on behalf of numerous specialty societies, individual physicians, physician group practices, manufacturers, hospitals, the AMA and other trade associations, diagnostic imaging centers, and the Medicare Payment Advisory Commission (MedPAC). We received a few general comments, but the vast majority of comments centered on five specific issues. We address the comments in the following order:

- General Comments.
- Authority to Include Nuclear Medicine Services and Supplies as Designated Health Services.
- Overutilization or Abuse.
- Beneficiary Access to Care.

- Quality of Care.
- Grandfathering Existing Arrangements or Delaying the Effective Date.

a. General Comments

Comment: One commenter questioned how our proposal would affect a physician's ability to refer patients to a positron emission tomography (PET) center that purchases radiopharmaceuticals (which are DHS under our proposal) from a company with which the referring physician has a financial relationship.

Response: The effect of this final rule with comment on a physician who has a financial relationship with a company that produces and supplies radiopharmaceuticals for PET scanning will depend on the nature of the physician's financial relationship with the supplying company and the supplying company's financial relationship with the PET center to which the physician wishes to refer. Depending on the facts, the arrangement described by the commenter could constitute an indirect compensation arrangement (as defined in § 411.354(c)(2). If an indirect compensation arrangement exists between the referring physician and the PET center, the physician may not refer to the PET center unless the arrangement complies with the indirect compensation arrangement exception at § 411.357(p).

Comment: One commenter expressed concern about our proposal and requested that we maintain the ability of radiation oncologists to order, perform and use as needed, diagnostic and therapeutic nuclear medicine services for radiation treatment planning and treatment delivery.

Response: We do not believe this final rule with comment will prohibit a radiation oncologist from ordering or performing diagnostic and therapeutic nuclear medicine services for purposes of radiation treatment planning and delivery. A ''referral'' does not include the request by a radiation oncologist for radiation therapy, including therapeutic nuclear medicine, if the request results from a consultation initiated by another physician and the services are furnished by or under the supervision of the radiation oncologist, or under the supervision of another radiation oncologist in the same group practice. In the March 26, 2004 final rule (69 FR 16065), we stated that the radiation oncologist exception in the definition of ''referral'' would also protect ''necessary and integral ancillary services requested, and appropriately supervised, by the radiation oncologist.'' We believe that diagnostic nuclear medicine procedures that are necessary and integral to the provision of radiation therapy fall within the scope of this protection. Accordingly, we are modifying the definition of ''Referral'' in § 411.351.

Comment: Two commenters suggested that the in-office ancillary services exception be modified or amended to prevent referring physicians from circumventing the physician self-referral law and its provisions.

Response: We understand the commenter's viewpoint, but the commenter's request goes beyond the scope of this rulemaking. We believe the in-office ancillary services exception strikes an appropriate balance between preventing program abuse without unduly interfering with the practice of medicine. However, we will continue to monitor the potential for abuse with respect to existing exceptions.

Comment: One commenter requested that we create a new exception for a physician's investment or ownership in a health care entity which provides nuclear medicine services and supplies, if the physician who refers patients to these entities directly supervises (on-site) the technicians or other personnel performing the nuclear medicine procedures on patients referred by that physician.

Response: Under section 1877(b)(4) of the Act, we may create a regulatory exception only if we determine that the exception would pose no risk of program or patient abuse. The commenter seems to believe that the potential for program and patient abuse would be eliminated by having an owner physician on-site when a technician performs a nuclear medicine procedure that the physician has ordered. We do not see how this requirement would eliminate the risk of overutilization or other program or patient abuse that arises when a physician self-refers to an entity with which he or she has a financial relationship.

b. Authority To Include Nuclear Medicine Services and Supplies as a Designated Health Services (DHS)

The physician self-referral statute, at section 1877(h)(6) of the Act, includes within the list of DHS, ''radiology services, including magnetic resonance imaging, computerized axial tomography, and ultrasound services,'' and ''radiation therapy services and supplies.'' We proposed to include diagnostic and therapeutic nuclear medicine as DHS because we believe they are within the statute's meaning of radiology services and radiation therapy services and supplies. We did not receive any comments disputing the assertion that therapeutic nuclear medicine services are radiation therapy services and supplies. However, regarding diagnostic nuclear medicine services, we received some comments that disagreed with our interpretation of the statute as well as some that agreed with our interpretation.

Comment: Three commenters noted that we proposed to include diagnostic nuclear medicine procedures within our definition of ''radiology and certain other imaging services'' in § 405.351. These commenters stated that ''other imaging services'' does not appear in the statute, and they asserted that the Congress rejected virtually identical (in their view) statutory phrasing. The commenters noted that when the Congress initially included radiology as a DHS in the Omnibus Budget Reconciliation Act of 1993, the language read ''radiology and other diagnostic services'' and that the Congress amended the statute in the Social Security Amendments of 1994 to delete the phrase ''and other diagnostic services.'' The commenters also asserted that if the Congress had meant to include nuclear medicine within the DHS category of radiology, it would have specifically mentioned diagnostic nuclear medicine, as it did magnetic resonance imaging (MRIs), computerized axial tomography (CT scans), and ultrasound services.

Response: We are including diagnostic nuclear imaging services in our definition of ''radiology and certain other imaging services'' because we believe they are radiology services within the meaning of section 1877(h)(6)(D) of the Act. We disagree with the commenter's assertion that we lack statutory authority to include certain imaging services in the DHS category described at section 1877(h)(6)(D) of the Act. We believe that the Congress meant to include all forms of radiology, that is, those that have traditionally been considered to be radiology, as well as certain other imaging services, such as ultrasound that may or may or not be considered to be radiology in the traditional sense. Further, we believe the Congress meant to include all forms of radiology, regardless of whether the particular form existed or was covered by Medicare on the date the statutory language was enacted or became effective. We believe that, by describing the DHS category as ''[r]adiology services, including [MRI, CAT scans], and ultrasound services,'' the Congress merely provided examples (rather than an exhaustive list) of some of the most

common forms of radiology other than x-rays.

Comment: Three commenters stated that nuclear medicine should not be considered a DHS because it is clinically and technically distinct from the services that the Congress enumerated when it defined the scope of radiology services. The commenters noted that the American Board of Nuclear Medicine defines nuclear medicine as ''the medical specialty that employs radionuclides to evaluate metabolic, physiologic and pathologic conditions of the body for purposes of diagnosis, therapy and research.'' According to the commenters, the introduction of radiolabeled, biologically active compounds into patients distinguishes nuclear medicine from radiology, which may involve the administration of biologically inert contrast agents, such as barium sulfate, iodine or gadolinium. One of these commenters stated that the mere use of radioactive material does not render a service radiology because radioactive materials are used in non-radiology services such as the performance of radioimmunoassay and irradiation of blood products.

Response: We are not persuaded that the common definitions of ''radiology'' cited in our proposed rule (70 FR 45854–55) are incorrect or do not include diagnostic nuclear imaging. As we stated in the proposed rule (70 FR 45855–56), radiology is ''that branch of the health sciences dealing with radioactive substances and radiant energy and with the diagnosis and treatment of disease by means of both ionizing (that is, x-rays) and non-ionizing (that is, ultrasound) radiations.'' (quoting Dorland's Illustrated Medical Dictionary). We noted in the proposed rule (70 FR 45855–56) that, ''[i]n more recent years, radiology has come also to embrace diagnosis by a method of organ scanning with the use of radioactive isotopes and non-ionizing radiation, such as ultrasound and nuclear magnetic resonance.'' (quoting Encyclopaedia Britannica outline). Diagnostic nuclear medicine services involve the use of radioactive substances and ionizing radiation for purposes of diagnosis. Like the other services the Congress identified in describing ''radiology services,'' the final product is an image used for purposes of diagnosis. We believe that the Congress intended to include as ''radiology services'' all forms of radiological imaging, regardless of whether exposure to radioactive materials or radiation is achieved through ingestion or eternal application and regardless of whether the form of radiation is ionizing or non-ionizing. We also note that certain professional medical organizations such as the AMA and the ACR consider diagnostic nuclear imaging to be a subspecialty of radiology.

We agree that the use of radioactive substances to perform a particular service does not, by itself, render that service ''radiology'' within the meaning of section 1877(h)(6)(D). We are not including as ''radiology and certain other imaging services'' any diagnostic nuclear medicine services that are not imaging services. We note that radioimmunoassay is a clinical laboratory service for purposes of section 1877, and irradiation of blood products is not a DHS.

Comment: We received several comments addressing whether nuclear medicine is a subspecialty of radiology. MedPAC stated that it strongly supports the proposal to include nuclear medicine services in the definition of ''radiology and certain other imaging services.'' MedPAC further stated its belief that the proposal is justified because physician groups such as the ACR and the AMA consider nuclear medicine to be a subspecialty of radiology. (We note that although the AMA objected to our proposal on the grounds that overutilization has not been shown for nuclear medicine services, the AMA did not assert that diagnostic nuclear medicine is not a subspecialty of radiology.) Another commenter stated that it is reasonable to include nuclear medicine as a DHS, but took exception to our statement in the proposed rule that diagnostic nuclear medicine is a subset of radiology. This commenter stated that the Nuclear Regulatory Commission (NRC) recognizes multiple alternative pathways to becoming a medical authorized user of isotopes in addition to certification from the American Board of Radiology. The commenter also noted that many different subspecialties, in addition to radiology, are recognized stakeholders with voting rights at the NRC Advisory Committee on the Medical Use of Isotopes. Two other commenters stated that according to the American Board of Medical Specialties, nuclear medicine and radiology are separate medical specialties, and that each is one of only 26 distinct medical disciplines subject to Primary Board Certification. These commenters stated that, although it is true that some nuclear medicine training is incorporated into the diagnostic radiology training program, and that the American Board of Radiology does include questions on nuclear medicine in its certification examination, physicians become eligible to take the American Board of Nuclear Medicine examination only after successfully completing a nuclear medicine residency program. Finally, one commenter objected to the proposal to include nuclear medicine as a DHS insofar as the proposal relates to the subspecialty of nuclear cardiology. According to this commenter, nuclear cardiology is the science of performing cardiac stress testing with the interpretation of nuclear images for purposes of determining a patient's diagnosis and prognosis; therefore, nuclear cardiology is not simply the interpretation of images, which the commenter stated is the case in nuclear medicine. The commenter asserted that the great majority of physicians certified by the Certification Board of Nuclear Cardiology are cardiologists rather than radiologists.

Response: We recognize that there is some difference of opinion, including among competing certification organizations, as to whether nuclear medicine is a subspecialty of radiology or whether it: (1) Is a subspecialty of both radiology and some other area of medicine; or (2) has achieved some type of independent status. However, even if nuclear medicine has achieved some type of independent status, it, nevertheless, is a form of radiology (as that term is commonly defined) and that therapeutic nuclear medicine is a form of radiation therapy. Likewise, the fact that cardiologists have found nuclear imaging to be particularly useful for evaluating heart disease and have developed a subspecialty in nuclear cardiology does not alter the essential fact that nuclear imaging employs radioactive material and is a form of radiology.

Comment: One commenter stated that our January 4, 2001 final rule clearly and permanently established the principle that nuclear medicine services are not radiology services. The commenter believes that the January 2001 rule fairly interpreted the law and that it is inappropriate to change the regulation in the absence of specific direction from the Congress in the form of a statutory change.

Response: We disagree with the commenter's belief that our regulations remain fixed for all time absent a change in the statute. As stated in the August 8, 2005 proposed rule, we believe that a better reading of the statute is that the radiology and radiation therapy DHS categories, as set forth in section 1877(h)(6) of the Act, encompass diagnostic and therapeutic nuclear medicine services, respectively. Therefore, we believe it is appropriate to

amend our regulations to include diagnostic and therapeutic nuclear medicine services within the respective DHS categories of radiology services and radiation therapy services and supplies.

c. Overutilization or Abuse

In the August 8, 2005 proposed rule, we cited several studies that suggest that a physician's referral patterns and utilization of nuclear medicine services and supplies closely correlate to whether the physician has a financial interest in the entity providing the services and supplies. We received several comments representing divergent views as to whether nuclear medicine services and supplies are at risk for abuse and overutilization when physicians have financial interests in the entities that provide the services and supplies.

Comment: One commenter supported our proposal to include nuclear medicine as a DHS and believed that there has been significant overutilization and abuse of this imaging modality in his State. The commenter believes that the problems have become more acute with the proliferation of PET and PET/CT imaging centers set up as joint ventures between select groups of referring physicians and venture capitalists in the State and requested that we prohibit these types of ventures.

Response: We welcome the commenter's observations regarding the impact on the utilization of PET and PET/CT imaging when physicians enter into arrangements with non-physician investors to own these imaging centers. Inclusion of nuclear medicine services and supplies as DHS likely will have an impact on these ventures (and potentially the utilization of PET and PET/CT imaging). However, whether or not PET joint ventures are abusive is not a determinative factor in our decision to include diagnostic and therapeutic nuclear medicine as DHS. Rather, our decision is based on our belief that these services and supplies properly are categorized as ''radiology and certain other imaging services'' and ''radiation therapy services and supplies'' within the meaning of the statute.

Comment: One commenter provided a summary of the findings from its own clinical and financial database regarding the incidence of physician self-referral for nuclear medicine services. The commenter asserted that the data show that self-referring providers are much more likely to order these types of services than those who do not self-refer.

Response: We appreciate the commenter's willingness to share its data regarding the incidence of physician self-referral for one specific type of nuclear imaging service (nuclear cardiology). The commenter's findings are consistent with the information we already have, including the studies cited in the August 8, 2005 proposed rule, that nuclear medicine services and supplies pose the same risk of abuse that the Congress intended to eliminate for other types of radiology, imaging and radiation therapy services and supplies.

Comment: Two commenters supported the expansion of the physician self-referral provisions to include nuclear medicine services and supplies. One of the commenters stated his or her belief that the proliferation of imaging units in non-hospital environments has contributed significantly to the increase in diagnostic imaging costs. This commenter urged that, although the advancement of PET technology has proven to be a clinically effective diagnostic imaging tool, the physician self-referral law should have equal extension and universal application to all imaging providers. The other commenter stated that recent studies of the effects of physician self-referral have shown that, when physicians have an investment interest in imaging equipment and have the opportunity to self-refer, their utilization is significantly higher than among physicians who refer their patients to a provider in which the referring physician has no financial interest. This commenter added that nuclear medicine services and supplies should have been included in the original listing, because the potential for abuse is no different than for CT scans or MRI scans. Both this commenter and MedPAC contend that our policy change will help limit referrals for nuclear medicine services that are based on financial, rather than clinical, reasons.

Response: We believe that the position advocated by these commenters is consistent with the studies we cited in the August 8, 2005 proposed rule. As we stated in the proposed rule, although we believe that diagnostic and therapeutic nuclear medicine services are radiology and radiation therapy services and supplies within the meaning of the statute, we would resolve any doubt as to this matter in favor of including them as DHS. After careful review of the information available to us currently, we believe it is appropriate to include diagnostic and therapeutic nuclear medicine services and supplies as DHS.

Comment: One commenter asserted that the risk of anti-competitive behavior would increase by limiting the parties that may provide nuclear medicine services, which is contrary to our rationale of protecting against abuse and ensuring quality patient care. In contrast, MedPAC referred to the 1994 GAO report (GAO/HEHS–95–2) and supported the inclusion of nuclear medicine as DHS. MedPAC contended that physician self-referral to nuclear medicine facilities undermines fair competition among these facilities because physician investors have a financial incentive to refer patients to the facility they own.

Response: We agree with MedPAC regarding potential anti-competitive behavior. Moreover, we do not agree with the other commenter's assertion that the inclusion of nuclear medicine services and supplies as DHS would limit the types of entities that may provide nuclear medicine services. Rather, the inclusion of these services and supplies as DHS merely limits the type of investors in the entities providing nuclear medicine services and supplies (that is, except for investors in either rural providers (as defined at § 411.356(c)(1) or entities that furnish the services in compliance with the in-office ancillary services exception, our proposal would limit physician investors to those who will not refer patients to the entity).

Comment: Several commenters asserted (but did not provide data or other proof) that nuclear medicine services are not at risk for the kind of overutilization that the physician self-referral law is designed to prevent. Other commenters disagreed with the proposal to include nuclear medicine services and supplies (and, in particular, nuclear cardiology) as DHS. The commenters stated that it is not possible to know if the rise in utilization of nuclear medicine services is due to abuse and believed that we must show evidence that these services are currently being abused before including nuclear medicine services and supplies as DHS.

Response: In the August 8, 2005 proposed rule, we referenced several studies concerning overutilization and increases in imaging services being performed in physician offices. We received comments, both data-driven and anecdotal, to support our belief that nuclear medicine services are subject to overutilization when physician self-interest is present, as is the case in many (but not all) office-based (or non-hospital) imaging procedures. We must emphasize, however, that our decision to include nuclear medicine as a DHS is based upon our current knowledge of nuclear medicine. We believe it is appropriate to interpret the DHS

categories described in section 1877(h)(6)(D) and (E) of the Act to include diagnostic nuclear medicine services and supplies and therapeutic nuclear medicine services and supplies, respectively.

Although we are conscious of a possible correlation between increased utilization and a showing of abuse, in the January 4, 2001 final rule with comment (66 FR 860), we stated that we did not believe the Congress intended us to review every possible service within a DHS category to determine its potential for overutilization. The Congress has already made the determination that the services in each of the eleven DHS categories are potentially subject to overutilization or other abuse. The risk of abuse and the potential for anti-competitive behavior inherent in physician self-referrals for nuclear medicine services simply provide additional support in favor of including nuclear medicine as DHS.

Comment: One commenter claimed that the increase in utilization of nuclear imaging services and supplies is due, at least in part, to the shift in site of service from the hospital setting to the physician office as well as a change in the standard of care in the treatment of patients due to improved technology and its applications. The commenter asserted that physician self-referral does not appear to be the primary driver of growth in imaging services, citing a study that shows that access to imaging technology, even in the absence of financial incentives, will result in increased utilization. The commenter contended that ''eliminating the ability of specialty physicians to perform and interpret imaging tests in their offices is not protection against the growth in utilization.''

Response: We are aware of the apparent shift in the site of service. However, we do not believe that the change in site of service accounts for all, or even most, of the increase in Medicare payments for nuclear medicine services. In fact, in its March 2005 ''Report to the Congress: Medicare Payment Policy'', MedPAC indicated that about 80 percent of the increase in the volume and intensity of imaging services, including nuclear medicine, between 1999 and 2002, was unrelated to any shift in service setting. We disagree with the commenter that inclusion of nuclear medicine services and supplies as DHS necessarily will prohibit physicians from performing and interpreting imaging tests in their offices. Certain arrangements and referrals may qualify for protection under existing provisions of the physician self-referral law and regulations (for example, the in-office ancillary services exception). In addition, even if we assume the commenter's sources are correct and utilization will increase with access to technology regardless of financial incentives for the referring physician, this does not affect the definition of radiology and radiation therapy, nor does it affect the proper inclusion of nuclear medicine services and supplies in these categories of DHS. We also note that, even if not the main ''driver'' of overutilization, self-interested referrals that cause any overutilization are problematic.

d. Beneficiary Access

We received numerous comments regarding the impact of our provision on beneficiary access to care. Our responses to these comments follow.

Comment: Several commenters expressed concern that our proposal would limit beneficiary access to nuclear medicine services. The AMA expressed concern about the potential impact of our proposal with regard to disruption of patient care, as well as access to these services. One of the commenters believes that our proposal will have a negative impact on the availability of PET scans, which constitute an important share of Medicare-covered nuclear imaging. In addition, another commenter raised concerns about where physicians would send patients for PET/CT scans.

Response: We recognize that the inclusion of nuclear medicine as a DHS may cause some changes in physician ownership of, or investment interests in PET centers; however, we do not agree with the commenters' assertions that our proposal would disrupt patient care and limit access to nuclear medicine services such as PET scans. We believe that most patients will continue to receive nuclear medicine services in the same location or vicinity where those services had been provided before. We see no reason why other providers or entities in the vicinity of existing PET centers would not be available or become available to furnish these services should a physician choose to divest any ownership or investment interest in an entity that furnishes nuclear medicine services. Alternatively, by restructuring their arrangements to comply with an existing exception, physicians may be able to continue referring patients to the same location for nuclear medicine services. In other words, whereas this rule may affect a physician's ability to refer to a PET center with which he or she has a financial relationship, there should be either alternative entities available to provide the services in the same setting or alternative business structures that would permit the physician to continue furnishing the services to his or her own patients. Other commenters, such as MedPAC, have also noted that there are a large number and variety of settings in which nuclear medicine services are available (such as hospitals, freestanding centers that are not owned by physicians, and physician offices). Therefore, we believe there would be no decrease in beneficiary access to care. Nevertheless, we have taken steps, as described in our discussion of the delayed effective date, to minimize any potential disruption of patient care or access to these services.

Comment: One commenter stated that there were not many PET scanners in the State of Oklahoma, and thus, patients would have to travel long distances for testing.

Response: We do not believe that this regulatory change will cause any significant disruption in patient care. The only referrals for PET scans that our proposal would prohibit are those made by physicians whose financial relationship with the entity furnishing the PET scans does not satisfy an exception such as the in-office ancillary services exception or the rural provider exception. If the financial relationship is an ownership interest in a non-rural provider, the physician may: (1) Divest the interest; (2) restructure the financial relationship so that it complies with an exception; or (3) maintain the interest and refer his or her patients to another entity for PET scans. If the physician chooses to divest or appropriately restructure his interest in the PET center, the physician's subsequent referrals to the PET center would not be prohibited under section 1877 of the Act, provided that the physician has no other financial relationship with the entity that fails to comply with an exception. We believe that the rural provider exception will ensure that beneficiaries in rural areas have continued access to nuclear medicine services.

Comment: One commenter expressed concern that if PET services are reclassified as DHS, physicians will be prevented from performing this service in mobile coaches due to the exclusion of mobile settings from the in-office ancillary exception. The commenter contended that beneficiary access will be limited where physicians cannot afford to operate PET services at fixed locations. The commenter requested that the final rule exclude PET services from DHS, or, in the alternative, create an exemption for physician ownership arrangements of PET units that contain

certain intrinsic checks against over-utilization.

Response: The commenter is correct that nuclear medicine services such as PET furnished in mobile coaches would not satisfy the ''same building'' element of the in-office ancillary services exception. However, if the entity furnishing the mobile services furnishes at least 75 percent of all the DHS it furnishes is to residents of a rural area (as defined in § 411.356(c)(c)(1)), it could meet the requirements of the rural provider exception. The commenter did not specify the nature of any intrinsic checks against overutilization and as we noted in Phase I (66 FR 861), medical necessity reviews and other efforts may not be sufficient to control overutilization. The statute permits us to create an exception only when there is no risk of fraud or program abuse. We have concluded that internal controls or medical necessity reviews are not necessarily effective controls on over-utilization, unfair competition, or other abuse. Therefore, we decline to adopt the requested exception. Additionally, we do not agree with the commenter's assertion that where physicians cannot afford to operate PET centers at fixed locations, the result will be to limit access to beneficiaries. As we have noted above, PET services are furnished in various settings other than physician-owned entities. Therefore, we do not believe our proposal will have a negative impact on beneficiary access.

e. Quality of Care

Comment: Two physicians disagreed with the proposal to include nuclear medicine services because they believed that the inclusion of nuclear medicine would reduce quality of care to patients. One of the physicians expressed specific concern about the timeliness of diagnosis and initiation of therapy. The physician recommended that we disseminate evidence-based guidelines on the appropriate use of nuclear medicine procedures for diagnosis and treatment, and measurement of the quality of the service provided. Additionally, the commenter suggested that Medicare reimbursement should be site-neutral, ownership-neutral, and based on the clinical appropriateness, safety, and quality of the service provided.

Response: We do not believe that the inclusion of nuclear medicine as a DHS would reduce quality of care. We have no data, and the commenter furnished no data or anecdotal evidence, to support the physician's contention that nuclear medicine facilities owned by non-physicians furnish lower quality of care, as may be evidenced by delays in diagnosis and the initiation of treatment. Regarding the commenter's other recommendations, this regulation is not the appropriate vehicle for addressing the development of evidence-based guidelines, measurement of the quality of the service, and changes in Medicare reimbursement.

Comment: One commenter stated that the increased referrals and physician investment may not be attributable to financial incentives but rather may be attributable to improved services and diagnosis achieved by utilizing better equipment. The commenter expressed concern that the adoption of this provision could have a negative impact on the future provision of quality health care as physicians may hesitate to invest in new technology or services. The commenter contended that patient care has improved due to physician investment in entities providing nuclear medicine and PET services. Specifically, the commenter stated that the ability to invest in new technology has led to improved diagnostic and treatment ability, and lower costs and improved patient care.

In addition, the commenter stated that physician investment has led to increased access to these services. According to the commenter, nuclear medicine and PET scan services require more expensive equipment than traditional radiology services and therefore physician investment in this equipment fills a necessary gap where large care providers have been unable to afford such equipment or choose not to acquire such equipment.

Response: We recognize that in some instances, new technology has led to improved diagnostic and treatment lower costs, and improved patient care; however, this final rule with comment does not prevent physicians from furnishing nuclear medicine services or utilizing better nuclear medicine equipment. Rather, and consistent with the purposes of the statute, the provisions of this final rule with comment restrict the circumstances under which physicians can financially benefit from DHS they order. Moreover, we believe that many non-physician owned entities will invest in new technology or new services and that quality of care will not be affected because most physicians will continue to refer patients for medically necessary services even where there is no potential for personal profit. Finally, we note that the commenters offered no evidence to support their claim that physician ownership of nuclear medicine facilities results in improved quality of care.

Comment: Some commenters opposed our proposal as it related to nuclear cardiology services, which the commenters asserted are integral to the diagnosis of heart disease and are performed primarily by cardiologists. One commenter stated that our proposal would prevent cardiologists from referring their patients for these services, thus causing primary care practitioners to refer these same patients directly to radiologists for nuclear testing, effectively bypassing a cardiologist's input on the appropriate approach to cardiac testing. The commenter asserted that nuclear medicine services performed in hospitals will be interpreted by radiologists who do not possess the specialized skills of cardiologists, and that our proposal would, therefore, negatively affect patient care.

Response: We are not persuaded by the commenters' concerns. First, our proposal would not prohibit a cardiologist from referring patients for nuclear medicine services; it would merely prohibit the physician from referring patients for these services to entities with which the physician has a financial relationship if that financial relationship does not comply with an existing exception. Second, we do not believe that patient care would be negatively affected if a cardiologist had to refer patients to a hospital for nuclear cardiology tests that would be interpreted by a radiologist. We are not convinced that cardiologists are the only individuals qualified to interpret these tests. Moreover, we believe that hospitals have every incentive to ensure that such tests are interpreted by qualified physicians (including cardiologists, if necessary).

Comment: Another commenter suggested that the inclusion of nuclear medicine as a DHS will limit the development of diagnostic testing facilities and thereby make the hospital setting the only permissible setting for nuclear cardiology.

Response: We do not agree that the effect of this rule will be to make the hospital setting the only permissible setting for nuclear cardiology. Physician-owned diagnostic testing facilities are not prohibited if the physician owners do not refer patients to the facilities or if the financial relationship complies with another exception, such as the rural provider or in-office ancillary services exceptions. Additionally, as MedPAC noted, there are numerous other types of non-hospital entities or non-physician owned entities that currently furnish these services.

f. Grandfathering Existing Arrangements or Delaying the Effective Date

In the August 8, 2005 proposed rule, we requested comments as to whether, or how, to minimize the impact on physicians who are currently parties to arrangements that involve nuclear medicine services and supplies (that is, by grandfathering certain arrangements, or by specifying a delayed effective date). Most commenters addressed this aspect of the proposed rule and either requested that current financial arrangements be grandfathered or recommended a delay in the effective date of our proposal.

Comment: Many commenters supported a delayed effective date for our proposal. Commenters suggested various lengths of delay in implementing our proposal. Several commenters favored delaying the effective date for three to six months. One of the commenters suggested that physicians should have at least five years to divest themselves of existing ownership or investment interests. This commenter believed that this would be the minimum period for physicians to recover a fair share of their capital investments and dispose of their assets without having to resort to ''bargain basement'' sales. The Society of Nuclear Medicine strongly encouraged a phased-in implementation over two to three years to decrease the chances that patient access would be compromised. The ACR recommended an effective date of January 1, 2006 with a 1-year ''grace period'' prior to enforcement.

Response: We have carefully considered the impact of our proposal on both beneficiaries and physicians. We have also considered our duty to implement the statute. Given our conclusion that nuclear medicine services and supplies are radiology and radiation therapy services and supplies, we do not believe we can delay the effective date beyond a reasonable period of time. After weighing these considerations, we have decided to delay the effective date of this regulatory change until January 1, 2007. We believe this delay provides adequate notice to the general public and a reasonable length of time for physicians to divest any existing ownership interests or to restructure their financial relationships with nuclear medicine entities so that they comply with a statutory or regulatory exception (if that is the course of action they choose to take), without unduly delaying our statutory duty to implement the statute. We are aware that many of the financial arrangements concerning nuclear medicine entities are complex and involve ownership, investment, and leasing arrangements. Accordingly, we are rejecting commenters' suggestions for a shorter or longer delay in implementation as being impractical or unreasonable.

Comment: Many commenters recommended that current financial arrangements be grandfathered and that the process be clearly implemented with as little administrative burden as possible. For example, some commenters urged us to grandfather existing PET joint ventures. The AMA stated its belief that CMS has the authority to implement a grandfather clause, and urged us to use it to avoid ''fire sales'' wherein physicians may not be able to recover the initial costs of their investment due to much greater supply than demand. Another commenter expressed a similar belief that the sales prices will reflect the forced nature of an immediate need to sell and be significantly below the prices that could be obtained in the absence of a grandfather provision. The commenter stated that ''even if CMS allowed a three to five year period to divest, investors may still not receive the full value of their investment.'' A physician stated that he and other physicians took risk by investing in nuclear medicine entities and believed that they should not have to divest their interest. Therefore, the physician advocated that we grandfather existing establishments and present ownership structures. Another commenter suggested that we grandfather financial relationships that were established prior to the effective date of the proposed rule.

A few commenters objected to grandfathering for several reasons including—(1) There was no precedent for grandfathering; (2) the statute does not permit grandfathering; and (3) to do so would negate the intent of the proposal.

Response: After reconsidering the issue, we question whether we have the authority to grandfather existing arrangements. Grandfathering existing arrangements would essentially require the creation of a new exception for physician financial relationships with certain nuclear medicine facilities. We have authority to create exceptions only for arrangements that pose no risk of patient or program abuse. We believe that physician self-referrals for diagnostic and therapeutic nuclear medicine services and supplies pose a risk of abuse, and we do not believe this risk is mitigated or eliminated simply because financial relationship was acquired before a particular date. Therefore, we have decided not to grandfather existing financial relationships between physicians and nuclear medicine facilities. However, we believe our decision to specify a delayed effective date will provide physicians with sufficient time to divest their ownership interests or to restructure appropriately existing financial arrangements.

2. Revisions to the List of Codes Identifying Nuclear Medicine Services

We have carefully reviewed the list of codes identifying nuclear medicine services and supplies (Nuclear Medicine Code List), as published in Addendum G of the August 8, 2005 PFS proposed rule. We have identified various additions and deletions.

Table 31 reflects the addition of new CPT and HCPCS codes that become effective January 1, 2006 or that became effective since the publication of the proposed rule. Table 31 also reflects the addition of codes that will be recognized by Medicare for payment purposes effective January 1, 2006.

Table 31 reflects the deletions necessary to conform the Nuclear Medicine Code List to the most recent publications of CPT and HCPCS codes. We have also deleted all C codes listed in the proposed rule because these are hospital outpatient services and are thus included in a different DHS category.

Table 31 identifies the nuclear medicine codes that will be included (effective January 1, 2007) in the DHS categories of radiology and certain other imaging services and radiation therapy services and supplies.

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TABLE 31: NUCLEAR MEDICINE HCPCS/CPT[1] CODES - SUBJECT TO THE PHYSICIAN SELF-REFERRAL PROHIBITION EFFECTIVE JANUARY 1, 2007

RADIOLOGY AND CERTAIN OTHER IMAGING SERVICES
78000 Thyroid, single uptake
78001 Thyroid, multiple uptakes
78003 Thyroid suppress/stimul
78006 Thyroid imaging with uptake
78007 Thyroid imaging,mult uptakes
78010 Thyroid imaging
78011 Thyroid imaging with flow
78015 Thyroid met imaging
78016 Thyroid met imaging/studies
78018 Thyroid met imaging, body
78020 Thyroid met uptake
78070 Parathyroid nuclear imaging
78075 Adrenal nuclear imaging
78099 Endocrine nuclear procedure
78102 Bone marrow imaging, ltd
78103 Bone marrow imaging, mult
78104 Bone marrow imaging, body
78110 Plasma, volume, single
78111 Plasma, volume, multiple
78120 Red cell mass, single
78121 Red cell mass, multiple
78122 Blood volume
78130 Red cell survival study
78135 Red cell survival kinetics
78140 Red cell sequestration
78185 Spleen imaging
78190 Platelet survival, kinetics
78191 Platelet survival
78195 Lymph system imaging
78201 Liver imaging
78202 Living imaging with flow
78205 Liver imaging (3D)
78206 Liver imaging (3D) with flow

RADIOLOGY AND CERTAIN OTHER IMAGING SERVICES
78215 Liver and spleen imaging
78216 Liver & spleen image/flow
78220 Liver function study
78223 Hepatobiliary imaging
78230 Salivary gland imaging
78231 Serial salivary imaging
78232 Salivary gland function exam
78258 Esophageal motility study
78261 Gastric mucosa imaging
78262 Gastroesophageal reflux exam
78264 Gastric emptying study
78270 Vit B-12 absorption exam
78271 Vit B-12 absrp exam, int fac
78272 Vit B-12 absorp, combined
78278 Acute GI blood loss imaging
78282 GI protein loss exam
78290 Meckel's divert exam
78291 Leveen/shunt patency exam
78299 GI nuclear procedure
78300 Bone imaging, limited area
78305 Bone imaging, multiple areas
78306 Bone imaging, whole body
78315 Bone imaging, 3 phase
78320 Bone imaging (3D)
78399 Musculoskeletal nuclear exam
78414 Non-imaging heart function
78428 Cardiac shunt imaging
78445 Vascular flow imaging
78456 Acute venous thrombus image
78457 Venous thrombosis imaging
78458 Ven thrombosis images, bilat
78459 Heart muscle imaging (PET)
78460 Heart muscle blood, single
78461 Heart muscle blood, multiple

RADIOLOGY AND CERTAIN OTHER IMAGING SERVICES
78464 Heart image (3d), single
78465 Heart image (3d), multiple
78466 Heart infarct image
78468 Heart infarct image (ef)
78469 Heart infarct image (3D)
78472 Gated heart, planar, single
78473 Gated heart, multiple
78478 Heart wall motion add-on
78480 Heart function add-on
78481 Heart first pass, single
78483 Heart first pass, multiple
78491 Heart image (pet), single
78492 Heart image (pet), multiple
78494 Heart image, spect
78496 Heart first pass add-on
78499 Cardiovascular nuclear exam
78580 Lung perfusion imaging
78584 Lung V/Q image single breath
78585 Lung V/Q imaging
78586 Aerosol lung image, single
78587 Aerosol lung image, multiple
78588 Perfusion lung image
78591 Vent image, 1 breath, 1 proj
78593 Vent image, 1 proj, gas
78594 Vent image, mult proj, gas
78596 Lung differential function
78599 Respiratory nuclear exam
78600 Brain imaging, ltd static
78601 Brain imaging, ltd w/flow
78605 Brain imaging, complete
78606 Brain imaging, compl w/flow
78607 Brain imaging (3D)
78608 Brain imaging (PET)
78609 Brain imaging (PET)

RADIOLOGY AND CERTAIN OTHER IMAGING SERVICES
78610 Brain flow imaging only
78615 Cerebral vascular flow image
78630 Cerebrospinal fluid scan
78635 CSF ventriculography
78645 CSF shunt evaluation
78647 Cerebrospinal fluid scan
78650 CSF leaking imaging
78660 Nuclear exam of tear flow
78699 Nervous system nuclear exam
78700 Kidney imaging, static
78701 Kidney imaging with flow
78704 Imaging renogram
78707 Kidney flow/function image
78708 Kidney flow/function image
78709 Kidney flow/function image
78710 Kidney imaging (3D)
78715 Renal vascular flow exam
78725 Kidney function study
78730 Urinary bladder retention
78740 Ureteral reflux study
78760 Testicular imaging
78761 Testicular imaging/flow
78799 Genitourinary, nuclear exam
78800 Tumor imaging/limited area
78801 Tumor imaging/mult areas
78802 Tumor imaging, whole body
78803 Tumor imaging (3D)
78804 Tumor imaging, whole body
78805 Abscess imaging, ltd area
78806 Abscess imaging, whole body
78807 Nuclear localization/abscess
78811 Tumor imaging (pet), limited
78812 Tumor image (pet)/skul-thigh
78813 Tumor image (pet) full-body

RADIOLOGY AND CERTAIN OTHER IMAGING SERVICES
78814 Tumor image pet/ct, limited
78815 Tumor image pet/ct skul-thigh
78816 Tumor image pet/ct full body
78890 Nuclear medicine data proc
78891 Nuclear med data proc
78999 Nuclear diagnostic exam
A4641 Diagnostic imaging agent
A4642 Satumomab pendetide per dome
A9500 Technetium TC99m sestamibi
A9502 Technetium TC99m tetrofosmin
A9503 Technetium TC99m medronate
A9504 Technetium Technetium TC99m apcitide
A9505 Thallous chloride TL 201/mci
A9507 Indium/111 capromab pendetid
A9508 Iobenguane sulfate I-131
A9510 Technetium TC99m disofenin
A9511 Technetium TC99m depreotide
A9512 Technetium TC99mpertechnetate
A9513 Technetium TC99m mebrofenin
A9514 Technetium TC99mpyprophosphate
A9515 Technetium TC99m pentetate
A9516 I-123 sodium iodide capsule
A9519 Technetium TC99mmacroag albu
A9520 Technetium TC99m sulfur clld
A9521 Technetium TC99m exmetazine
A9522 Indium111ibritumomabtiuxetan
A9524 Iodinated I-131 serumalbumin
A9526 Ammonia N-13, per dose
A9528 Dx I131 so iodide cap millic
A9529 Dx I131 so iodide sol millic
A9531 Dx I131 so iodide microcurie
A9533 I-131 tositumomab diagnostic
A9700 Echocardiography contrast
Q3000 Rubidium RB-82

RADIOLOGY AND CERTAIN OTHER IMAGING SERVICES
Q3002 Gallium ga 67
Q3003 Technetium TC99m bicisate
Q3004 Xenon xe 133
Q3005 Technetium TC99m mertiatide
Q3006 Technetium TC99m glucepatate
Q3007 Sodium phosphate p32
Q3008 Indium 111-in pentetreotide
Q3009 Technetium TC99m oxidronate
Q3010 Technetium TC99mlabeledrbcs
Q3011 Chromic phosphate p32
Q3012 Cyanocobalamin cobalt co57
Q9945 LOCM<=149mg/ml iodine, 1 ml
Q9946 LOCM 150-199mg/ml iodine,1ml
Q9947 LOCM 200-249mg/ml iodine,1ml
Q9948 LOCM 250-299mg/ml iodine,1ml
Q9949 LOCM 300-349mg/ml iodine,1ml
Q9950 LOCM 350-399mg/ml iodine,1ml
Q9951 LOCM>=400 mg/ml iodine,1ml
Q9952 Inj Gad-base MR contrast,ml
Q9953 Inj Fe-bse MR contrast,ml
Q9954 Oral MR contrast, 100ml
Q9955 Inj perflexane lip micros, ml
Q9956 Inj octafluoropropane mic,ml
Q9957 Inj perflutren lip micros, ml
RADIATION THERAPY SERVICES AND SUPPLIES
79005 Nuclear rx, oral admin
79101 Nuclear rx, iv admin
79200 Nuclear rx, intracav admin
79300 Nuclr rx, interstit colloid
79403 Hematopoietic nuclear rx
79440 Nuclear rx, intra-articular
79445 Nuclear rx, intra-arterial
79999 Nuclear medicine therapy

RADIOLOGY AND CERTAIN OTHER IMAGING SERVICES
A9517 Th I131 so iodide cap millic
A9523 Yttrium90ibritumomabtiuxetan
A9530 Th I123 so iodide sol millic
A9532 I-125 serum albumin micro
A9534 I-131 tositumomab therapeut
A9600 Strontium-89 chlorida
A9605 Samarium sm153 lexidronamm
A9699 Noc therapeutic radiopharm
Q3001 Brachytherapy radioelements
Q3007 Sodium phosphate p32
Q3011 Chromic phosphate p32

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C. Annual Update to the Code List

In § 411.351, we specify that the entire scope of four DHS categories is defined in a list of CPT/HCPCS codes (the Code List), which is updated annually to account for changes in the most recent CPT and HCPCS publications. The DHS categories defined and updated in this manner are:

- Clinical laboratory services.
- Physical therapy, occupational therapy, and speech-language pathology services.
- Radiology and certain other imaging services.
- Radiation therapy services and supplies.

The updated Code List appears as Addendum H in this PFS final rule with comment and is available on our Web site at *http://cms.hhs.gov/medlearn/refphys.asp.* We also include in the Code List those items and services that may qualify for either of the following two exceptions to the physician self-referral prohibition:

- EPO and other dialysis-related drugs furnished in or by an ESRD facility (§ 411.355(g)).
- Preventive screening tests, immunizations or vaccines (§ 411.355(h)).

The Code List was last updated in the CY 2005 PFS final rule (69 FR 66236). The updated all-inclusive Code List effective January 1, 2006 (except as otherwise noted for specific nuclear medicine codes) is presented in Addendum H of this final rule with comment.

1. Response to Comments

We received the following comment:

Comment: One commenter suggested incorporating the Code List in the National Physician Fee Relative Value File as discussed in the CY 2005 PFS final rule (69 FR 66373).

Response: We have decided not to incorporate the Code List into the National Physician Fee Relative Value File as suggested by the commenter. That file is updated quarterly and would entail a quarterly update to the PFS. In discussions with the commenter (an association representing medical group practices), we learned that its primary goal was to have the Code List in a format that could be downloaded. The previous Code Lists were generally posted on our web site as PDF files that could not be downloaded. Therefore, we will be posting the updated Code List on our physician self-referral Web site in an Excel spreadsheet that may be downloaded.

2. Revisions Effective for 2006

Tables 32 and 33, in this section, identify the additions and deletions, respectively, to the comprehensive Code List published in Addendum L of the CY 2005 PFS final rule. Tables 32 and 33 also identify the additions and deletions to the lists of codes used to identify the items and services that may qualify for the exceptions in § 411.355(g) (regarding EPO and other dialysis-related outpatient prescription drugs furnished in or by an ESRD facility) and in § 411.355(h) (regarding preventive screening tests, immunizations and vaccines).

We will consider comments for the codes listed in Tables 32 and 33, if we receive them by the date specified in the **DATES** section of this final rule with comment. We will not consider any comment that advocates a substantive change to any of the DHS defined in § 411.351.

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TABLE 32: Additions to the Physician Self-Referral List of CPT[1]/HCPCS Codes

CLINICAL LABORATORY SERVICES	
0103T	Holotranscobalamin
0104T	At rest cardio gas rebreathe
0111T	RBC membranes fatty acids
0140T	Exhaled breath condensate ph
78267	Breath tst attain/anal C-14
78268	Breath test analysis, C-14
PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH-LANGUAGE PATHOLOGY SERVICES	
0019T	Extracorp shock wv tx,ms nos
92506	Speech/hearing evaluation
97760	Orthotic mgmt and training
97761	Prosthetic training
97762	C/O for orthotic/prosth use
RADIOLOGY AND CERTAIN OTHER IMAGING SERVICES	
76376	3d render w/o postprocess
76377	3d rendering w/postprocess
RADIATION THERAPY SERVICES AND SUPPLIES	
77421	Stereoscopic x-ray guidance
77422	Neutron beam tx, single
77423	Neutron beam tx, complex
DRUGS USED BY PATIENTS UNDERGOING DIALYSIS	
J0882	Darbepoetin alfa, esrd use
J0886	Epoetin alfa, esrd
J1751	Iron dextran 165 injection
J1752	Iron dextran 267 injection
PREVENTIVE SCREENING TESTS, IMMUNIZATIONS AND VACCINES	
[No additions]	

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TABLE 33: Deletions to the Physician Self-Referral List of CPT[1]/HCPCS Codes

CLINICAL LABORATORY SERVICES	
0010T	Tb test, gamma interferon
0023T	Phenotype drug test, hiv 1
PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH-LANGUAGE PATHOLOGY SERVICES	
96115	Neurobehavior status exam
97020	Microwave therapy
97504	Orthotic training
97520	Prosthetic training
97703	Prosthetic checkout
G0279	Extracorp shock tx, elbow epi
G0280	Extracorp shock tx other than
RADIOLOGY AND CERTAIN OTHER IMAGING SERVICES	
76375	3d/holograph reconstr add-on
RADIATION THERAPY SERVICES AND SUPPLIES	
G0242	Multisource photon ster plan
G0338	Linear accelerator stero pln
DRUGS USED BY PATIENTS UNDERGOING DIALYSIS	
J1750	Iron dextran
Q4054	Darbepoetin alfa, ersd use
Q4055	Epoetin alfa, esrd use
PREVENTIVE SCREENING TESTS, IMMUNIZATIONS AND VACCINES	
[No deletions]	

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The additions specified in Table 32 generally reflect new CPT and HCPCS codes that become effective January 1, 2006 or that became effective since our last update. Table 32 also reflects the addition of codes that will be recognized by Medicare for payment purposes effective January 1, 2006. It does not reflect the addition of the nuclear medicine codes that were discussed in section V.B.2 of this preamble. For the convenience of physicians and DHS entities, nuclear medicine codes appear on Addendum H with an asterisk to indicate that they will become effective on January 1, 2007 for physician self-referral purposes.

As a result of reviewing nuclear medicine codes as set forth in the CPT, we are adding CPT 78267 and 78268 for urea breath tests and analyses to the DHS category of clinical laboratory services. Although these codes appear under the nuclear medicine subheading in the CPT, they do not represent imaging services. Therefore, we do not consider CPT 78267 and 78268 radiology or other imaging services. We are adding these codes to the Code List under the clinical laboratory services category. This is consistent with our payment policy, since these codes are reimbursed under the clinical laboratory fee schedule. We note that there are other tests involving the use of radiopharmaceuticals (for example, CPT 83519) that are identified by the Code List as clinical laboratory services.

Additionally, we are adding CPT code 92506 for the evaluation of speech, language, voice, communication, and/or auditory processing. We had deleted this code in the Phase II physician self-referral interim final rule published on March 26, 2004 (69 FR 16054) because it represented an audiology service. However, Medicare does not provide reimbursement for CPT code 92506 as an audiology service. Under Medicare, that code is only reimbursed as a speech-language pathology service and therefore must be added to the Code List.

VI. Physician Fee Schedule Update for CY 2006

A. Physician Fee Schedule Update

The PFS update is determined using a formula specified by statute. Under section 1848(d)(4) of the Act, the update

is equal to the product of 1 plus the percentage increase in the Medicare Economic Index (MEI) (divided by 100) and 1 plus the update adjustment factor (UAF). For CY 2006, the MEI is equal to 2.8 percent (1.028). The UAF is −7.0 percent (0.930). The product of the MEI (1.028) and the UAF (0.930), equals the CY 2006 update of −4.4 percent (0.95604).

Our calculations of these figures are explained in this section.

B. The Percentage Change in the Medicare Economic Index (MEI)

The MEI measures the weighted-average annual price change for various inputs needed to produce physicians' services. The MEI is a fixed-weight input price index, with an adjustment for the change in economy-wide multifactor productivity. This index, which has 2000 base year weights, is comprised of two broad categories: physician's own time and physician's PE.

The physician's own time component represents the net income portion of business receipts and primarily reflects the input of the physician's own time into the production of physicians' services in physicians' offices. This category consists of two subcomponents: (1) Wages and salaries; and (2) fringe benefits.

The physician's PE category represents nonphysician inputs used in the production of services in physicians' offices. This category consists of wages and salaries and fringe benefits for nonphysician staff and other nonlabor inputs. The physician's PE component also includes the following categories of nonlabor inputs: Office expense; medical materials and supplies; professional liability insurance; medical equipment; and other expenses. The components are adjusted to reflect productivity growth in physicians' offices by the 10-year moving average of productivity in the private nonfarm business sector. Table 34 presents a listing of the MEI cost categories with associated weights and percent changes for price proxies for the 2006 update. For CY 2006, the increase in the MEI is 2.8 percent, which includes a 1.0 percent productivity offset based on the 10-year moving average of multifactor productivity. This is the result of a 3.2 percent increase in physician's own time and a 4.4 percent increase in physician's PE. Within the physician's PE, the largest increase occurred in professional liability insurance, which increased 13.7 percent.

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TABLE 34: Increase in the Medicare Economic Index Update for CY 2006[1]

Cost Categories and Price Measures	CY 2000 Weights[2]	CY 2006 Percent Changes
Medicare Economic Index Total, productivity adjusted	N/A	2.8
Productivity: 10-year moving average of multifactor productivity, private nonfarm business sector[3]	N/A	1.0
Medicare Economic Index Total, without productivity adjustment	100.000	3.8
1. Physician's Own Time[4]	52.466	3.2
a. Wages and Salaries: Average Hourly Earnings, private Nonfarm	42.730	2.5
Fringe Benefits: Employment Cost Index, benefits, private nonfarm	9.735	6.1
2. Physician's Practice Expense[4]	47.534	4.4
a. Nonphysician Employee Compensation	18.653	3.6
(1) Wages and Salaries: Employment Cost Index, wages and salaries, weighted by occupation	13.808	2.7
(2) Fringe Benefits: Employment Cost Index, fringe benefits, white collar	4.845	6.1
b. Office Expense: Consumer Price Index for Urban Areas (CPI-U), housing	12.209	2.9
c. Drugs and Medical Materials and Supplies	4.319	3.2
(1) Medical Materials and Supplies: Producer Price Index (PPI), surgical appliances and supplies/CPI-U, medical equipment and supplies (equally weighted)	2.011	1.4
(2) Pharmaceuticals: Producer Price Index (PPI ethical prescription drugs)	2.308	4.6
d. Professional Liability Insurance: Professional liability insurance Premiums[5]	3.865	13.7
e. Medical Equipment: PPI, medical instruments and equipment	2.055	0.9
f. Other Expenses	6.433	2.1

1. The rates of historical change are estimated for the 12-month period ending June 30, 2005, which is the period used for computing the CY 2006 update. The price proxy values are based upon the latest available Bureau of Labor Statistics data as of September 15, 2005.

2. The weights shown for the MEI components are the 2000 base-year weights, which may not sum to subtotals or totals because of rounding. The MEI is a fixed-weight, Laspeyres-type input price index whose category weights indicate the distribution of expenditures among the inputs to physicians' services for CY 2000. To determine the MEI level for a given year, the price proxy level for each component is multiplied by its 2000 weight. The sum of these products (weights multiplied by the price index levels) over all cost categories yields the composite MEI level for a given year. The annual percent change in the MEI levels is an estimate of price change over time for a fixed market basket of inputs to physicians' services.

3. On February 1, 2005, Bureau of Labor Statistics released the estimates of nonfarm multifactor productivity growth for 2002. Therefore, we used the most recently available information (thru CY 2002) to develop the productivity adjustment for the CY 2006 update.
4. The measures of productivity, average hourly earnings, Employment Cost Indexes, as well as the various Producer and Consumer Price Indexes can be found on the Bureau of Labor Statistics Web site-http://stats.bls.gov.
5. Derived from data collected from several major insurers (the latest available historical percent change data are for the period ending second quarter of 2005).

C. The Update Adjustment Factor

Section 1848(d) of the Act provides that the PFS update is equal to the product of the MEI and the UAF. The UAF is applied to make actual and target expenditures (referred to in the statute as ''allowed expenditures'') equal. Allowed expenditures are equal to actual expenditures in a base period updated each year by the sustainable growth rate (SGR). The SGR sets the annual rate of growth in allowed expenditures and is determined by a formula specified in section 1848(f) of the Act.

1. Calculation Under Current Law

Under section 1848(d)(4)(B) of the Act, the UAF for a year beginning with 2001 is equal to the sum of the following—

• Prior Year Adjustment Component. An amount determined by—

+ Computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services for the prior year (the year prior to the year for which the update is being determined) and the amount of the actual expenditures for those services for that year;

+ Dividing that difference by the amount of the actual expenditures for those services for that year; and

+ Multiplying that quotient by 0.75.

• Cumulative Adjustment Component. An amount determined by—

+ Computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services from April 1, 1996, through the end of the prior year and the amount of the actual expenditures for those services during that period;

+ Dividing that difference by actual expenditures for those services for the prior year as increased by the SGR for the year for which the UAF is to be determined; and

+ Multiplying that quotient by 0.33.

Section 1848(d)(4)(E) of the Act requires the Secretary to recalculate allowed expenditures consistent with section 1848(f)(3) of the Act. Section 1848(f)(3) specifies that the SGR (and, in turn, allowed expenditures) for the upcoming CY (2006 in this case), the current CY (2005) and the preceding CY (2004) are to be determined on the basis of the best data available as of September 1 of the current year. Allowed expenditures are initially estimated and subsequently revised twice. The second revision occurs after the CY has ended (that is, we are making the final revision to 2004 allowed expenditures in this final rule with comment). Once the SGR and allowed expenditures for a year have been revised twice, they are final.

Table 35 shows annual and cumulative allowed expenditures for physicians' services from April 1, 1996 through the end of the current CY, including the transition period to a CY system that occurred in 1999. Also shown is the SGR corresponding with each period. The calculation of the SGR is discussed in detail below.

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TABLE 35: Annual and Cumulative Allowed and Actual Expenditures for Physicians' Services from April 1, 2006 through the End of the Current Calendar Year

Period	Annual Allowed Expenditures ($ in billions)	Annual Actual Expenditures ($ in billions)	Cumulative Allowed Expenditures ($ in billions)	Cumulative Actual Expenditures ($ in billions)	FY/CY SGR
4/1/96-3/31/97	$48.9	$48.9	$48.9	$48.9	N/A
4/1/97-3/31/98	50.5	49.4	99.4	98.4	FY 1998=3.2%
4/1/98-3/31/99	52.6	50.5	152.0	148.9	FY 1999=4.2%
1/1/99-3/31/99	13.3	13.1	([1])	148.9	FY 1999=4.2%
4/1/99-12/31/99	42.1	39.5	([2])	188.4	FY 2000=6.9%
1/1/99-12/31/99	55.3	52.6	194.0	188.4	FY 1999/2000[(3)]
1/1/00-12/31/00	59.4	58.1	253.4	246.5	CY 2000=7.3%
1/1/01-12/31/01	62.0	66.3	315.4	312.8	CY 2001=4.5%
1/1/02-12/31/02	67.2	71.0	382.6	383.8	CY 2002=8.3%
1/1/03-12/31/03	72.1	76.8	454.6	460.6	CY 2003=7.3%
1/1/04-12/31/04	76.8	87.2	531.5	549.3	CY 2004=6.6%

1/1/05-12/31/05	80.4	93.3	611.8	642.5	CY 2005=4.6%
1/1/06-12/31/06	81.7	NA	693.6	NA	CY 2006=1.7%

([1]) Allowed expenditures for the first quarter of 1999 are based on the FY 1999 SGR.

([2]) Allowed expenditures for the last three quarters of 1999 are based on the FY 2000 SGR.

([3]) Allowed expenditures in the first year (April 1, 1996--March 31, 1997) are equal to actual expenditures. All subsequent figures are equal to quarterly allowed expenditure figures increased by the applicable SGR. Cumulative allowed expenditures are equal to the sum of annual allowed expenditures. We provide more detailed quarterly allowed and actual expenditure data on our web site under the Medicare Office of the Actuary's (OACT) publications at the following address: http://www.cms.hhs.gov/statistics/actuary/. We expect to update the web site with the most current information later this month.

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Consistent with section 1848(d)(4)(E) of the Act, Table 35 includes our final revision of allowed expenditures for 2004, a recalculation of allowed expenditures for 2005, and our initial estimate of allowed expenditures for 2006. To determine the UAF for 2006, the statute requires that we use allowed and actual expenditures from April 1, 1996 through December 31, 2005 and the 2006 SGR. Consistent with section 1848(d)(4)(E) of the Act, we will be making further revisions to the 2005 and 2006 SGRs and 2005 and 2006 allowed expenditures. Because we have incomplete actual expenditure data for 2005, we are using an estimate for this period. Any difference between current estimates and final figures will be taken into account in determining the UAF for future years.

We are using figures from Table 35 in the statutory formula illustrated below:

$$UAF = \frac{Target_{05} - Actual_{05}}{Actual_{05}} \times .75 + \frac{Target_{4/96-12/05} - Actual_{4/96-12/05}}{Actual_{05} \times SGR_{06}} \times .33$$

UAF = Update Adjustment Factor
$Target_{05}$ = Allowed Expenditures for 2005 or $80.4 billion
$Actual_{05}$ = Estimated Actual Expenditures for 2005 = $93.3 billion
$Target_{4/96-12/05}$ = Allowed Expenditures from 4/1/1996–12/31/2005 = $611.8 billion
$Actual_{4/96-12/05}$ = Estimated Actual Expenditures from 4/1/1996–12/31/2005 = $642.5 billion
SGR_{06} = 1.7 percent (1.017)

$$\frac{\$80.4 - \$93.3}{\$93.3} \times .75 + \frac{\$611.8 - \$642.5}{\$93.3 \times 1.017} \times .33 = -0.210$$

Section 1848(d)(4)(D) of the Act indicates that the UAF determined under section 1848(d)(4)(B) of the Act for a year may not be less than −0.070 or greater than 0.03. Since −0.210 is less than −0.070, the UAF for 2005 will be −0.070.

Section 1848(d)(4)(A)(ii) of the Act indicates that 1 should be added to the UAF determined under section 1848(d)(4)(B) of the Act. Thus, adding 1 to −0.070 makes the UAF equal to 0.930.

VII. Allowed Expenditures for Physicians' Services and the Sustainable Growth Rate

A. Medicare Sustainable Growth Rate

The SGR is an annual growth rate that applies to physicians' services paid by Medicare. The use of the SGR is intended to control growth in aggregate Medicare expenditures for physicians' services. Payments for services are not withheld if the percentage increase in actual expenditures exceeds the SGR. Rather, the PFS update, as specified in section 1848(d)(4) of the Act, is adjusted based on a comparison of allowed expenditures (determined using the SGR) and actual expenditures. If actual expenditures exceed allowed expenditures, the update is reduced. If actual expenditures are less than allowed expenditures, the update is increased.

Section 1848(f)(2) of the Act specifies that the SGR for a year (beginning with 2001) is equal to the product of the following four factors:

(1) The estimated change in fees for physicians' services;

(2) The estimated change in the average number of Medicare fee-for-service beneficiaries;

(3) The estimated projected growth in real gross domestic product (GDP) per capita; and

(4) The estimated change in expenditures due to changes in statute or regulations.

In general, section 1848(f)(3) of the Act requires us to publish SGRs for 3 different time periods, no later than November 1 of each year, using the best data available as of September 1 of each year. Under section 1848(f)(3)(C)(i) of the Act, the SGR is estimated and subsequently revised twice (beginning with the FY and CY 2000 SGRs) based on later data. (There were also provisions in the Act to adjust the FY 1998 and FY 1999 SGRs. See the February 28, 2003 **Federal Register** (68 FR 9567) for a discussion of these SGRs). Under section 1848(f)(3)(C)(ii) of the Act, there are no further revisions to the SGR once it has been estimated and subsequently revised in each of the 2 years following the preliminary estimate. In this final rule with comment, we are making our preliminary estimate of the 2006 SGR, a revision to the 2005 SGR, and our final revision to the 2004 SGR.

B. Physicians' Services

Section 1848(f)(4)(A) of the Act defines the scope of physicians' services covered by the SGR. The statute indicates that ''the term 'physicians' services' includes other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physician's office, but does not include services furnished to a Medicare+Choice plan enrollee.'' We published a definition of physicians' services for use in the SGR in the **Federal Register** (66 FR 55316) on November 1, 2001. We defined physicians' services to include many of the medical and other health services listed in section 1861(s) of the Act. For purposes of determining allowed expenditures, actual expenditures, and SGRs, we have specified that physicians' services include the following medical and other health services if bills for the items and services are processed and paid by Medicare carriers (and those paid through intermediaries where specified):

- Physicians' services.
- Services and supplies furnished incident to physicians' services.
- Outpatient physical therapy services and outpatient occupational therapy services.
- Antigens prepared by, or under the direct supervision of, a physician.
- Services of physician assistants, certified registered nurse anesthetists, certified nurse midwives, clinical psychologists, clinical social workers, nurse practitioners, and certified nurse specialists.
- Screening tests for prostate cancer, colorectal cancer, and glaucoma.

- Screening mammography, screening pap smears, and screening pelvic exams.
- Diabetes outpatient self-management training services.
- Medical nutrition therapy services.
- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests (including outpatient diagnostic laboratory tests paid through intermediaries).
- X-ray, radium, and radioactive isotope therapy.
- Surgical dressings, splints, casts, and other devices used for the reduction of fractures and dislocations.
- Bone mass measurements.
- An initial preventive exam.
- Cardiovascular screening blood tests.
- Diabetes screening tests.
- Telehealth services.
- Physician work and resources to establish and document the need for a power mobility device (see 70 FR 50940).

Telehealth services and the power mobility device related services have been added because they meet the statutory criteria for services to be included in the SGR (that is, these services are commonly performed or furnished by a physician or in a physician's office).

We appreciate the tremendous number of comments we received expressing concern about the negative update for 2006. Those comments are summarized below, along with our responses.

Comment: Commenters noted that physicians' costs are rising, while fees are being cut. The cumulative impact of the projected reductions from 2006 to 2012 will be about −27 percent, while the MEI increase over this same period is projected to be 19 percent. Commenters predict that, based on the MEI alone, payments should increase by 3.5 percent in 2006. Instead, payments are being reduced. Because commercial insurance carriers base their payment updates upon Medicare's PFS, the overall negative impact is compounded.

Many comments predict that costs to provide care will soon exceed reimbursement. The result will be that patient quality of care will be compromised, with doctors taking drastic measures to cut costs of health care delivery to remain solvent. Eventually, physicians will be unable to absorb the losses, and they will refuse or limit Medicare patients, resulting in reduced access to care. Costs will shift to inpatient settings, which will be more costly for Medicare, less efficient in delivering care, and yield worse health outcomes for beneficiaries.

Commenters recommend that the SGR be replaced with an appropriate inflation rate (for example, the projected change in prices or the MEI). Updates should be linked to changes in the actual costs of medical practice.

Response: We are fully cognizant of the potential implications of seven years of negative physician updates, remain concerned regarding those trends, and are closely monitoring physicians' participation in the Medicare program, as well as beneficiaries' access to care. At the same time, simply increasing spending by adding larger updates into the current volume-based payment system that is already experiencing increases of 12 to 13 percent or more per year would have an adverse effect from the standpoint both Medicare's finances and beneficiary premiums and cost-sharing, and therefore would not promote better quality care.

However, it is clear, under our current system, that there is much potential for physicians to improve the value of our health care spending. Under the current system, there are substantial variations in resources and in spending growth for the same medical condition in different practices and in different parts of the country, without apparent differences in quality and outcomes, and without a clear basis in existing medical evidence. A study published in 2003 looked at regional variations in the number of services received by Medicare patients who were hospitalized for hip fractures, colorectal cancer, and acute myocardial infarction.[6] The researchers found that patients in higher spending areas received approximately 60 percent more care, but that quality of care in those regions was no better on most measures and was even worse for several preventive care measures. Further, there are many examples of steps that physicians can take to improve quality while helping to keep overall costs down (for example, management of diabetic patients may result in reduced hospital admissions).

Because it is critical for CMS payment systems to support better outcomes for our beneficiaries while safeguarding Medicare's finances, we are working closely and collaboratively with medical professionals and the Congress to consider changes to increase the effectiveness of the payment methodology Medicare uses to compensate physicians for providing services to Medicare beneficiaries. We are engaging physicians on issues of quality and performance with the goal of supporting the most effective clinical and financial approaches to achieve better health outcomes for Medicare beneficiaries. We are committed to developing reporting and payment systems that enable us to support and reward quality, and to improve care without increasing overall Medicare costs. When clear, valid and widely accepted quality measures are in place, pay-for-performance is a tool that can enable our reimbursement methodology to better support efforts to improve quality and to avoid unnecessary costs.

Currently, hospitals and physicians are paid under separate systems. Under these systems, physicians do not receive credit for avoiding unnecessary hospitalizations by providing better care to their patients. However, in our physician group practice demonstration project, physicians could receive performance-based payments derived from savings from preventing chronic disease complications, avoiding hospitalizations, and improving quality of care.

The evidence is increasing that when healthcare providers are given incentives for achieving higher quality care, they respond by taking a range of steps from the simple to the high-tech to improve care and reduce costs (for example, by avoiding unnecessary hospital care). This is not surprising, as our health professionals are dedicated, and they want to do everything in their power to get the best care to their patients. So when we support high quality care, we enable professionals to do what they do best.

We have seen this approach work first-hand with hospital payments where we have tied the annual hospital payment update to quality measure reporting. It has had a positive impact on the availability of quality information, with about 98 percent of the hospitals subject to this provision reporting quality data.

Reporting clinically valid quality measures is an important step toward achieving major improvements in quality. If you cannot measure something, it is hard to take steps to improve it. We have been working hard in close collaboration with health professionals and other stakeholders to promote the development of better measures for reporting on the quality of care.

Comment: Most commenters support the overall development of measures related to the quality and efficiency of care furnished by physicians, but many

[6] Fisher, Elliott S., MD, MPH; David E. Wennberg, MD, MPH; Therese A. Stukel, Ph.D.; Daniel J. Gottlieb, MS; F.L. Lucas, Ph.D.; and Etoile L. Pinder, MS, ''The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care,'' in The Annals of Internal Medicine, February 18, 2003, Vol 138, Issue 4.

are concerned that the promotion of high quality health care is incompatible with the current SGR system. Any performance measures may involve additional services or administrative actions, and will exacerbate the problems with the current volume-based update formula. Some commenters note that many electronic health record systems with decision support tools specifically prompt physicians to perform additional diagnostic tests and screenings, which, in turn, could offset any projected savings. Overall, pay-for-performance will drive spending over the target, negatively impacting future updates, and thereby penalizing physicians for participating in pay-for-performance.

Commenters also expressed the concern that health information technology systems, a key component of many pay for performance programs, will be unaffordable to physicians facing payment cuts.

Response: Medicare needs to encourage and reward efficiency and high quality care, and not simply pay for more services, regardless of the quality of those services or of the impact that those services have on patient health.

Currently, the physician payment system does not always recognize clinically appropriate care. For example, Medicare will pay for a duplicate x-ray or blood test right before surgery if a hospital does not coordinate care adequately with the physician's office. The physician payment system should support, encourage, and provide an incentive for physicians to improve quality and reduce unnecessary Medicare costs by avoiding unnecessary services (like duplicate tests).

Another way the current physician payment system fails to encourage clinically appropriate care is the way in which it tends to steer patient care decisions. Oncologists, for example, are paid less for transitioning a terminal patient to palliative care and focusing on quality of life issues, than for recommending and providing intensive procedures, even if the side effects of those procedures are significant and the benefits negligible. In addition, the current payment system does not reward physicians who actively prevent readmissions for patients with heart failure or diabetes.

Linking a portion of Medicare payments to valid measures of quality and effective use of resources could give physicians more direct incentives to implement the innovative ideas and approaches that actually result in improvements in both the value and quality of care that people with Medicare receive.

We have been working on the technical methods for supporting effective, simple, and least burdensome reporting and payment based on these measures. In the years ahead, it is expected that electronic record systems can be developed that would provide information that is needed to measure and report on quality while fully protecting patient confidentiality. However, while electronic health records would greatly facilitate the accurate and efficient use of information on quality measures and quality improvement, progress on supporting quality improvement should not be delayed until electronic health records are widely used. Indeed, taking steps now to promote quality reporting and improvement also could promote the adoption of and investment by physicians in electronic records, which would facilitate more efficient quality reporting and quality improvement activities. In the short term, there is considerable evidence that information on a broad range of quality measures can be obtained adequately via information transmitted on existing claims. Steps will be taken to ensure patient confidentiality when obtaining these quality measures.

In addition, we believe that several Federal government actions are creating favorable market conditions for the adoption of health information technology. First, HHS, through the Office of the National Coordinator for Health Information Technology, is leading a public-private partnership to reduce the risk of Health Information Technology investment by: harmonizing health information standards; certifying health IT products to ensure consistency with standards; addressing variations in privacy and security policies that can pose challenges to interoperability; and, developing an architecture for nationwide sharing of electronic health information. Second, two recently proposed rules discussed an exception to the Stark statute and a safe harbor to the anti-kickback statute for e-prescribing technology and electronic health records, which would create opportunities for physicians to acquire health information technology free or at a reduced cost.

In January 2006, we will start the process of collecting quality information on services provided by physicians in certain specialties and subspecialties through the voluntary reporting of G-Codes for quality indicators. The G-codes were established by Medicare to supplement claims data with clinical data pertinent to a variety of quality measures, without the burdens of chart abstraction. Those quality measures have been achieved through a process of study and consensus with input from physicians and others.

Comment: Commenters suggested that we should assume the leadership in pushing the Congress to enact legislation preventing a negative update for 2006, and to replace the SGR with a more sustainable system. They stated that it would be a show of good faith and leadership for CMS to take the administrative action to remove drugs from the SGR and levels of allowed expenditures retroactively to 1996, even prior to legislative action. The commenters opined that if CMS makes the administrative changes now, worth about $111 billion, then the legislative price tag will drop and will increase the likelihood of Congressional action to fix the SGR permanently.

Response: We are concerned about the projections of seven years of negative updates to physician payments and are closely monitoring the current volume-based payment system for physicians' services. The CMS Office of the Actuary (OACT) estimated under its Mid-Session Baseline that removing drugs from the SGR and allowed expenditures retroactively to 1996 would cost $111 billion. We note that our current estimate is that removing drugs prospectively would not provide relief to the negative updates projected for 2006 and the succeeding several years. OACT estimates removing drugs prospectively would cost an additional $36 billion over 10 years. These changes would also have significant impacts on beneficiary premiums. Consequently, while we have carefully reviewed our authority to make this administrative change, we also have been working with the Congress and health professional organizations on payment reforms that would improve the effectiveness of the payment methodology for physicians without increasing overall Medicare costs.

Comment: Many commenters indicated that they support removing the costs of Part B covered drugs from the calculation of the SGR, and provided or referenced legal opinions and Congressional support for this view. Some commented that they find no basis in the statute for ever including drugs in the definition of physicians' services, and CMS is therefore obligated to remove them retroactively from the SGR.

Commenters contend that the rapid increase in the price of drugs is a major contributor to increased spending on physician-administered drugs. Therefore, it is not logical to include

drugs in calculating the target, because the growth in expenditures on these drugs is not controlled by physicians and reduced payments to physicians will not affect future spending on Part B drugs provided incident to physicians' services.

Some commenters noted that including drugs in the SGR has not led to controls on drug spending and, as a result, removing them would not lead to increased spending on drugs. These commenters opined that spending on drugs is rising far more rapidly than spending on physicians' and other practitioners' services. According to these commenters, in 1996 drugs represented 3.7 percent of the physician spending portion of the SGR calculation, but in 2004, drugs represented 9.8 percent.

Commenters stated that growth in Medicare spending on drugs is driven primarily by the introduction of expensive new drugs to the Medicare population and extensive marketing (including direct-to-consumer advertising), and that prices are set by drug companies that are not impacted by negative updates to the Medicare physician fee schedule.

Some commenters indicated that the increase in drug spending is due to government policies that encourage the rapid development of drugs.

Response: The statute provides the Secretary with clear authority to specify the services that are included in the SGR. Section 1848(f)(4)(A) of the Act indicates that the term ''physicians services'' includes other items and services specified by the Secretary that are commonly performed or furnished by a physician or in a physician's office. We disagree with the comments suggesting that the Secretary does not have the authority to include drugs in the definition of physicians' services for purposes of determining allowed expenditures, actual expenditures, and the SGR. We define ''physicians' services'' to include many of the medical and other health services listed in section 1861(s) of the Act that meet the criterion of being commonly performed by a physician or furnished in a physicians' office. Because ''incident to'' drugs covered under 1861(s) of the Act are commonly furnished in physicians' offices, we include these items in the calculation of the SGR and allowed expenditures.

We have indicated in the past that retrospective removal of drugs from the SGR is statutorily difficult. For example, the statute requires the estimated SGR be refined twice based on actual data. We do not see a legal basis to re-estimate the SGR and allowed expenditures for a year after it has been estimated and revised twice. Further, as noted previously, our current estimate is that removing drugs retroactively from the SGR would not result in a positive update for 2006 or the succeeding few years.

Comment: CMS has clearly excluded drugs from physicans' services for purposes of administering other Medicare payment provisions. For example, in the December 13, 2002 Inherent Reasonableness rule (67 FR 76684), CMS applied inherent reasonableness to certain Part B items and services other than physicians' services as defined and paid for under section 1848 of the Act, stating that drugs are paid under section 1842(o) of the Act and not section 1848 of the Act. In response to comments, CMS asserted that the inherent reasonableness provision should therefore be applied to drugs administered in physicians' offices.

Response: As we pointed out in the December 13, 2002 **Federal Register**, the statute specifies that inherent reasonableness applies to certain Part B items and services other than physicians' services as defined and paid for under section 1848 of the Act. Drugs are paid under section 1842(o) of the Act and not section 1848 of the Act. The application of inherent reasonableness to payments for drugs relates to the payment methodology for drugs, not to whether they are physicians' services. Accordingly, our decision to permit the application of inherent reasonableness to compute the payment amounts for Part B drugs is not inconsistent with our determination that it is appropriate to include drugs furnished incident to a physician's services in the definition of physicians' services for purposes of computing the SGR and actual and allowed expenditures under the physician fee schedule.

Comment: We received many comments criticizing the ability of the current SGR methodology to appropriately reflect many factors affecting physician spending. For example, malpractice insurance continues to escalate; there is a general increase in overhead and inflation; and there are additional expenses associated with regulatory compliance for which the SGR is not adjusted. The SGR does not account for trends in utilization attributable to important technological improvements, improved quality of care, and efficiency in the health care system overall.

Also, commenters stated that payment updates under the SGR formula are tied to GDP, which bears little relationship to patients' health care needs or physicians' practice costs because medical needs of individual patients are not related to the overall economy. Patients' needs do not diminish in slower economies, and are therefore wholly unrelated to measures of GDP. In addition, Medicare patients have more chronic diseases and require more medications, tests, counseling, and education than the average health care consumer; therefore, the time required to see a Medicare patient is disproportionately high relative to the Medicare payment received. Commenters are concerned that services to Medicare beneficiaries are not adequately reflected in GDP because they are disproportionately more expensive than services provided to the rest of the population.

Commenters believe that reliance on GDP makes the SGR an inherently unstable system, and unnecessarily detracts from an appropriate focus on an analysis of actual data regarding the increasing costs of providing physicians' services to Medicare beneficiaries. The formula fails to consider the growth in beneficiary population and utilization factors unrelated to economic trends. The GDP is a factor beyond physicians' control and it is inappropriate to use it as a means to control growth in Medicare spending.

Response: Under section 1848(d)(4) of the Act, the PFS update is equal to the product of the percentage increase in the MEI and the UAF. The UAF is determined by comparing allowed and actual expenditures from prior years and the current year, and adjusting the update to account for the difference. The SGR is used to calculate allowed expenditures, and the GDP is one of the components used to calculate the SGR. Change in enrollment in fee-for-service Medicare is one of the factors used in computing the SGR. (See section 1848(f)(2)(B) of the Act.)

The percentage change in the MEI is one of the key components used to update the PFS CF. In accounting for the weighted average price change for various inputs involved with producing physicians' services, the MEI measures inflation in physician practice costs and general wage levels. Elements of the MEI include measures of physicians' PEs, including nonphysician employee compensation, office expenses, medical material and supplies, professional liability insurance, and medical equipment. As noted above in this section, professional liability insurance experienced the largest percentage increase of any component of the MEI for 2006.

The GDP is a general measure of economic growth. It is not intended to reflect factors specific to operating a medical practice because these are captured in the MEI. Currently, the statute requires that we use the GDP as a component of the SGD, which is then used to calculate the target level of expenditures.

We disagree with the comment that use of GDP makes the SGR inherently unstable. The SGR is based on the 10 year average of GDP, so year-to-year changes are averaged over a significant period, modulating any fluctuations from one year to the next.

Comment: Some commenters stated that physicians are penalized with pay cuts when Medicare spending on physicians' services exceeds the SGR spending target, yet the SGR is not adjusted to take into account many factors beyond physicians' control, including government policies that, although good for patients, promote Medicare spending on physicians' services. Specifically, government-induced increases in spending on physicians' services should be accurately reflected in the SGR target. The impact of these government policies on spending for physicians' services is ignored or underestimated in calculating the target. New government policies often result not only in direct expenditures, but can also lead to ancillary new expenditures that are not appropriately reflected in the target. For example, new preventive benefits can lead to additional physician services, such as office visits. CMS has not provided details as to how its estimates of costs for new benefits are calculated under section 1848(f)(2)(D) of the Act, making it impossible to judge the accuracy of its target adjustments.

Commenters also contend there have been a number of regulatory changes that encouraged growth in spending on physicians' services by shifting services from facilities to physicians' offices. Services previously provided by facilities (and not included in the calculation of actual and allowed expenditures in the base year) are now provided in physicians' offices, and are not reflected in the current level of allowed expenditures. For example, the growth in therapy services was influenced by the elimination of cost-based reimbursement to many facilities. This led many rehabilitation agencies to terminate their provider numbers and enroll as physical therapists in private practice. It also provided incentives for hospitals to discharge patients sooner, leading to increased therapy services paid under the physician fee schedule.

Commenters urge CMS to adjust for other spending increases attributable to quality improvement programs that trigger physicians' services. Commenters provided examples of increased administrative demands and costs being imposed upon physicians through Federal program requirements including: transition of new and dually eligible beneficiaries into Medicare Part D drug plans; electronic prescribing; national demonstration on pay for performance; and Medicare policies on competitive acquisition for outpatient drugs and biologicals under Part B.

Response: As described previously, the calculation of the SGR is determined by statute. Policy changes due to statute or regulation are required to be accounted for in the SGR calculation. For example, past changes that were expected to result in increased spending for therapy were reflected in prior years' SGR calculations. (See the CY 2002 Final Rule (66 FR 55320).) Similarly, last year we made an adjustment to the SGR to account for increased Medicare spending for physicians' services as a result of the MMA provisions providing for Medicare coverage of an initial preventive physical examination, cardiovascular, and diabetes screening tests. (See the CY 2005 Final Rule (69 FR 66388).) Based on subsequent data, we will revise these estimates and adjust the SGR as discussed in section F. of this preamble.

Comment: We received many public comments that argued for adjusting the SGR for changes in expenditures resulting from national coverage determinations (NCDs). According to these comments, any changes in national Medicare coverage policy, such as a Program Memorandum or an NCD, constitute regulatory changes for purposes of computing the SGR. The commenters indicate that, because the statute provides the authority to adjust the SGR for statutory or regulatory changes, any new coverage initiative should be taken into account in determining the SGR.

Commenters noted that CMS has previously stated that it is very difficult to estimate any costs or savings associated with specific coverage decisions. Additionally, CMS has stated that adjustments to the target for NCDs would likely be of such a small magnitude that it would have little effect on future projected updates. Commenters noted that CMS adjusts Medicare Advantage payments to account for NCDs, so clearly CMS has some means to estimate the costs of NCDs. Some commenters contracted with a private research firm to estimate the costs of several NCDs, to illustrate that it is possible to make such estimates and to provide a sense of their magnitude. These studies indicated that although certain individual NCDs do not significantly increase Medicare spending, some NCDs do have a significant impact. Furthermore, even if individually, the impacts of new NCDs are relatively minor, taken in the aggregate, even those NCDs with marginal impact contribute to rising utilization.

Response: The large majority of Medicare spending is for services that are covered at local carrier discretion. While we may establish national coverage (or noncoverage) for a new item or service with a defined statutory benefit category, the NCD does not necessarily increase Medicare spending to the extent that the service has or would have been covered at local carrier discretion in the absence of a NCD. Because Medicare would cover these services without an NCD, it is unclear whether there are any additional costs associated with the NCDs. We may also issue an NCD to clarify Medicare coverage for existing items or services. This decision may establish national policy that replaces differing local practices. In these cases, there may not have been consistency among Medicare carriers as to whether an item or service qualified for coverage based on existing statute or regulation. Thus, our NCD would replace differing local practices with a national determination which, based on existing law and regulations, clarifies Medicare coverage for an item or service. Spending may or may not increase or decrease depending upon the degree to which the particular item or service is currently being covered by Medicare carriers and whether the decision is to establish coverage or noncoverage of the item or service. As a result, at this time, we do not intend to make any adjustment to the SGR to account for new NCDs. We will examine this issue further, for example, to determine the impact of new NCDs on Medicare spending for physicians' services above and beyond what would happen with LCDs, though we expect that these NCDs would have, at most, a limited impact.

Comment: In response to the discussion in the proposed rule about substantial growth in Medicare spending in certain areas, commenters suggested that growth may be due to previously unmet needs that are only now being met. The commenters pointed out that nothing in the data presented suggested that the increased levels of service were inappropriate. Some commenters noted that since the introduction of the SGR methodology

many procedures have begun to move from settings, such as outpatient facilities, to physicians' offices. As a result, the full cost of these procedures is not reflected in either the SGR or allowed expenditures. Commenters believe CMS must recognize this shift in site of service and make appropriate adjustments to the target.

Response: We are taking collaborative steps to better understand these trends, including what changes in utilization are likely to be associated with important health improvements and which have limited or questionable health benefits. We have been reviewing the technical aspects of this situation in detail with health policy experts as well as the AMA and various specialty societies. Generally, our analysis indicates that while there are some identifiable factors that have contributed to higher spending, these factors do not account for a substantial part of the growth in spending on physicians' services. Major contributors to the rapid increase in spending are more frequent and more intensive following visits, more frequent and more complex imaging, more frequent and more intensive minor procedures such as physical therapy, more frequent and more complex laboratory tests, and increased use of drugs in physicians' offices. There is also a lot of evidence of much variation in the use of these services without much evidence of impact on health outcomes. This variation reinforces our commitment to continuing to develop better evidence on what additional spending is effective as well as to moving our payment system toward recognizing better quality care. Moreover, the statute does not provide a mechanism for us to recognize additional expenditures on physicians' services resulting from changes in medical practice that are not also changes in law and regulation. As a result, we do not see any legal basis to make adjustment to the SGR to reflect the additional expenditures associated with these factors.

C. Preliminary Estimate of the SGR for 2006

Our preliminary estimate of the 2006 SGR is 1.7 percent. We first estimated the 2006 SGR in March and made the estimate available to the Medicare Payment Advisory Commission and on our web site. Table 36 shows that March 2005 and our current estimates of the factors included in the 2006 SGR.

TABLE 36.—2006 SGR CALCULATION

Statutory factors	March estimate	Current estimate
Fees	2.8 percent (1.028)	2.7 percent (1.027).
Enrollment	−2.5 percent (0.975)	−3.1 percent (0.969).
Real Per Capita GDP	2.3 percent (1.023)	2.2 percent (1.022).
Law and Regulation	0.0 percent (1.000)	0.0 percent (1.000).
Total	2.5 percent (1.025)	1.7 percent (1.017)

Note: Consistent with section 1848(f)(2) of the Act, the statutory factors are multiplied, not added, to produce the total (that is, $1.027 \times 0.969 \times 1.022 \times 1.000 = 1.017$). A more detailed explanation of each figure is provided in section VII.F.1 of this preamble.

D. Revised Sustainable Growth Rate for 2005

Our current estimate of the 2005 SGR is 4.6 percent. Table 37 shows our preliminary estimate of the 2005 SGR that was published in the CY 2005 Final Rule (69 FR 66386) and our current estimate.

TABLE 37.—2005 SGR CALCULATION

Statutory factors	Estimate from CY 2005 Final Rule	Current estimate
Fees	1.3 percent (1.013)	0.8 percent (1.008).
Enrollment	−0.3 percent (0.997)	0.3 percent (1.003).
Real Per Capita GDP	2.2 percent (1.022)	2.2 percent (1.022).
Law and Regulation	1.0 percent (1.010)	1.2 percent (1.010).
Total	4.3 percent (1.043)	4.6 percent (1.046).

A more detailed explanation of each figure is provided in section VII.F.2 of this preamble.

E. Final Sustainable Growth Rate for 2004

The SGR for 2004 is 6.6 percent. Table 38 shows our preliminary estimate of the 2004 SGR from the CY 2004 Final Rule (68 FR 63249), our revised estimate from the CY 2005 Final Rule (69 FR 66387) and the final figures determined using the latest available data.

TABLE 38.—2004 SGR CALCULATION

Statutory factors	Estimate from CY 2004 Final Rule	Estimate from CY 2005 Final Rule	Final
Fees	2.7 percent (1.027)	1.4 percent (1.014)	1.3 percent (1.013).
Enrollment	1.7 percent (1.017)	1.7 percent (1.017)	1.3 percent (1.013).
Real Per Capita GDP	2.8 percent (1.028)	2.2 percent (1.022)	2.1 percent (1.021).
Law and Reg	0.0 percent (1.000)	1.5 percent (1.015)	1.7 percent (1.017).
Total	7.4 percent (1.074)	7.0 percent (1.070)	6.6 percent (1.066).

A more detailed explanation of each figure is provided in section VII.F.3.

F. Calculation of 2006, 2005, and 2004 Sustainable Growth Rates

1. Detail on the 2006 SGR

All of the figures used to determine the 2006 SGR are estimates that will be revised based on subsequent data. Any differences between these estimates and the actual measurement of these figures will be included in future revisions of the SGR and allowed expenditures and incorporated into subsequent PFS updates.

• *Factor 1—Changes in Fees for Physicians' Services (Before Applying Legislative Adjustments) for 2006*

This factor is calculated as a weighted-average of the 2006 fee increases for the different types of services included in the definition of physicians' services for the SGR. Medical and other health services paid using the PFS are estimated to account for approximately 83.1 percent of total allowed charges included in the SGR in 2006 and are updated using the MEI. The MEI for 2006 is 2.8 percent. Diagnostic laboratory tests are estimated to represent approximately 7.2 percent of Medicare allowed charges included in the SGR for 2006. Medicare payments for these tests are updated by the Consumer Price Index for Urban Areas (CPI–U). However, section 629 of the MMA specifies that diagnostic laboratory services will receive an update of 0.0 percent from 2004 through 2008.

Drugs are estimated to represent 9.7 percent of Medicare allowed charges included in the SGR in 2006. Sections 303 and 304 of the MMA require Medicare to pay for most drugs at 106 percent of ASP beginning January 1, 2005. We estimated a weighted-average change in fees for drugs included in the SGR (using the ASP plus 6 percent pricing methodology) of 4.1 percent for 2006. Table 39 shows the weighted-average of the MEI, laboratory and drug price changes for 2006.

TABLE 39

	Weight	Update
Physician	0.831	2.8
Laboratory	0.072	0.0
Drugs	0.097	4.1
Weighted-average	1.000	2.7

We estimate that the weighted-average increase in fees for physicians' services in 2006 under the SGR (before applying any legislative adjustments) will be 2.7 percent.

• *Factor 2—The Percentage Change in the Average Number of Part B Enrollees From 2005 to 2006*

This factor is our estimate of the percent change in the average number of fee-for-service enrollees from 2005 to 2006. Services provided to Medicare Advantage (MA) plan enrollees are outside the scope of the SGR and are excluded from this estimate. OACT estimates that the average number of Medicare Part B fee-for-service enrollees will decrease by −3.1 percent from 2005 to 2006. Table 40 illustrates how this figure was determined.

TABLE 40

	2005	2006
Overall	39.536 million	40.059 million.
Medicare Advantage (MA)	5.070 million	6.654 million.
Net	34.466 million	33.405 million.
Percent Increase		−3.1 percent.

An important factor affecting fee-for-service enrollment is beneficiary enrollment in MA plans. Because it is difficult to estimate the size of the MA enrollee population before the start of a calendar year, at this time we do not know how actual enrollment in MA plans will compare to current estimates. For this reason, the estimate may change substantially as actual Medicare fee-for-service enrollment for 2006 becomes known.

• *Factor 3—Estimated Real Gross Domestic Product Per Capita Growth in 2006*

We estimate that the growth in real GDP per capita from 2005 to 2006 will be 2.2 percent (based on the 10-year average GDP over the ten years of 1997–2006). Our past experience indicates that there have also been changes in estimates of real per capita GDP growth made before the year begins and the actual change in GDP computed after the year is complete. Thus, it is possible that this figure will change as actual information on economic performance becomes available to us in 2006.

• *Factor 4—Percentage Change in Expenditures for Physicians' Services Resulting From Changes in Statute or Regulations in 2006 Compared With 2005*

The statutory and regulatory provisions that will affect expenditures in CY 2006 relative to CY 2005 are estimated to have an impact on expenditures of less than 0.05 percent. These provisions include the expiration of the temporary higher payments to physicians in Alaska, the new powered wheelchair code for physicians, and the impact of the new IVIG service discussed elsewhere in this final rule with comment.

2. Detail on the 2005 SGR

A more detailed discussion of our revised estimates of the four elements of the 2005 SGR follows.

• *Factor 1—Changes in Fees for Physicians' Services (Before Applying Legislative Adjustments) for 2005*

This factor was calculated as a weighted-average of the 2005 fee increases that apply for the different types of services included in the definition of physicians' services for the SGR.

We estimate that services paid using the PFS account for approximately 84.3 percent of total allowed charges included in the SGR in 2005. These services were updated using the 2005 MEI of 3.1 percent. We estimate that diagnostic laboratory tests represent approximately 7.0 percent of total allowed charges included in the SGR in 2005. Medicare payments for these tests are updated by the CPI–U. However, section 629 of the MMA specifies that diagnostic laboratory services will receive an update of 0.0 percent from 2004 through 2008.

We estimate that drugs represent 8.7 percent of Medicare allowed charges included in the SGR in 2005. Sections 303 and 304 of the MMA require

Medicare to pay for most drugs at 106 percent of ASP beginning January 1, 2005. We now estimate a weighted-average change in fees for drugs included in the SGR of −21.1 percent for 2005. The estimated weighted-average change in the CY 2005 Final Rule was −14.7 percent. The decline in the estimate is due to updated ASP data. Table 41 shows the weighted-average of the MEI, laboratory and drug price changes for 2005.

TABLE 41

	Weight	Update
Physician	0.843	3.1
Laboratory	0.070	0.0
Drugs	0.087	−21.1
Weighted-average	1.000	0.8

After taking into account the elements described in Table 41, we estimate that the weighted-average increase in fees for physicians' services in 2005 under the SGR (before applying any legislative adjustments) will be 0.8 percent. Our estimate of this factor in the CY 2005 Final Rule was 1.3 percent. The reduction from 1.3 percent to our current estimate of 0.8 percent is primarily due to application of the drug pricing changes required by sections 303 and 304 of the MMA.

• *Factor 2—The Percentage Change in the Average Number of Part B Enrollees From 2004 to 2005*

OACT estimates that the average number of Medicare Part B fee-for-service enrollees (excluding beneficiaries enrolled in M+C plans) increased by 0.3 percent in 2005. Table 42 illustrates how we determined this figure.

TABLE 42

	2004	2005
Overall	39.048 million	39.536 million.
Medicare+Choice	4.683 million	5.070 million.
Net	34.366 million	34.466 million.
Percent Increase		0.3 percent.

OACT's estimate of the 0.3 percent change in the number of fee-for-service enrollees, net of M+C enrollment for 2005 compared to 2004, is greater than our original estimate of −0.3 percent in the CY 2005 Final Rule (69 FR 66388). While our current projection based on data from 8 months of 2005 is greater than our original estimate of −0.3 percent when we had no data, it is still possible that our final estimate of this figure will be different once we have complete information on 2005 fee-for-service enrollment.

• *Factor 3—Estimated Real Gross Domestic Product Per Capita Growth in 2005*

We estimate that the growth in real GDP per capita will be 2.2 percent for 2005 (based on the 10-year average GDP over the ten years of 1996–2005). Our past experience indicates that there have also been differences between our estimates of real per capita GDP growth made prior to the year's end and the actual change in this factor. Thus, it is possible that this figure will change further as complete actual information on 2005 economic performance becomes available to us in 2006.

• *Factor 4—Percentage Change in Expenditures for Physicians' Services Resulting From Changes in Statute or Regulations in 2005 Compared With 2004*

There are a number of statutory provisions that affect the 2005 SGR. As mentioned previously in the preamble, sections 303 and 304 of the MMA changed Medicare payment for drugs. These provisions also changed Medicare payments for the administration of drugs. Section 303(a)(1) of the MMA amended section 1848(c)(2) of the Act to require the Secretary to make a number of changes that increased Medicare payment for drug administration beginning January 1, 2004. These changes permanently increased Medicare payments for drug administration by a weighted-average of 110 percent. Section 303(a)(4) of the MMA required an additional transitional adjustment (temporary increase) to Medicare's payment for drug administration of 32 percent for 2004 and 3 percent for 2005. The change in the transitional adjustment of 32 percent for 2004 to 3 percent for 2005 would reduce Medicare payments for drug administration between 2004 and 2005. However, some of this reduction will be lessened because we also adopted changes to the codes and payment amounts for drug administration based on recommendations from the AMA's CPT Editorial Panel and Relative Value Update Committee (RUC), under the authority of section 1848(c)(2)(J) of the Act. We further increased PFS payments by paying separately for injections provided on the same day as another PFS service. We estimate that changes to our policy on injections and the changes to our drug administration payments taken together increased physician spending by 0.8 percent.

There are several other statutory provisions that are estimated to increase Medicare spending for physicians' services under the SGR. Section 413(a) of the MMA establishes a 5 percent increase in the PFS payment for services provided in physician scarcity areas. Section 413(b) of the MMA improves the procedures for paying the 10 percent PFS bonus payment for services provided in health professional shortage areas. We estimate that the provisions of section 413 of the MMA will increase Medicare PFS payments by 0.1 percent.

Sections 611 through 613 of the MMA provide Medicare coverage for an initial preventive physical examination, cardiovascular and diabetes screening tests. We estimate that new Medicare coverage for these preventive services will increase spending for physicians' services under the SGR by 0.3 percent. Taken together, we estimate that all of the statutory provisions for 2005 will increase Medicare spending for physicians' services by 1.2 percent.

3. Detail on the 2004 SGR

A more detailed discussion of our final revised estimates of the four elements of the 2004 SGR follows.

• *Factor 1—Changes in Fees for Physicians' Services (Before Applying Legislative Adjustments) for 2004*

This factor was calculated as a weighted-average of the 2004 fee increases that apply for the different types of services included in the definition of physicians' services for the SGR.

Services paid using the PFS accounted for approximately 83.3

percent of total Medicare allowed charges included in the SGR for 2004 and are updated using the MEI. The MEI for 2004 was 2.9 percent. Diagnostic laboratory tests represented approximately 6.8 percent of total 2004 Medicare allowed charges included in the SGR and are updated by the CPI–U. However, section 629 of the MMA specifies that diagnostic laboratory services will receive an update of 0.0 percent from 2004 through 2008. Drugs represented approximately 9.9 percent of total Medicare allowed charges included in the SGR for 2004. Historically, Medicare paid for drugs under section 1842(o) of the Act at 95 percent of average wholesale price (AWP). However, with some exceptions, sections 303 and 304 of the MMA generally require Medicare to pay for drugs at 85 percent of the AWP determined as of April 1, 2003, or a specified percentage of AWP based on studies by the Government Accountability Office and the Office of the Inspector General in 2004. We implemented section 303 and 304 of the MMA in an interim final rule making changes to the PFS for 2004, which appeared in the **Federal Register** on January 7, 2004 (see 69 FR 1086). Taking sections 303 and 304 of the MMA into account, we estimate a weighted-average change in fees for drugs included in the SGR of −11.5 percent for 2004. Table 43 shows the weighted-average of the MEI, laboratory, and drug price increases for 2004.

TABLE 43

	Weight	Update
Physician	0.833	2.9
Laboratory	0.068	0.0
Drugs	0.099	−11.5
Weighted-average	1.000	1.3

After taking into account the elements described in Table 43, we estimate that the weighted-average increase in fees for physicians' services in 2004 under the SGR (before applying any legislative adjustments) was 1.3 percent.

• *Factor 2—The Percentage Change in the Average Number of Part B Enrollees From 2003 to 2004*

We estimate the increase in the number of fee-for-service enrollees (excluding beneficiaries enrolled in M+C plans) from 2003 to 2004 was 1.3 percent. Our calculation of this factor is based on complete data from 2004. Table 44 illustrates the calculation of this factor.

TABLE 44

	2003	2004
Overall	38.465 million	39.048 million.
Medicare+Choice	4.655 million	4.683 million.
Net	33.810 million	34.366 million.
Percent Increase		1.3 percent.

• *Factor 3—Estimated Real Gross Domestic Product Per Capita Growth in 2004*

We estimate that the growth in real per capita GDP was 2.1 percent in 2004 (based on the 10-year average GDP over the ten years of 1995–2004). This figure is a final one based on complete data for 2004.

• *Factor 4—Percentage Change in Expenditures for Physicians' Services Resulting From Changes in Statute or Regulations in 2004 Compared With 2003*

There are four statutory provisions that increased 2004 Medicare spending relative to 2003. Section 412 of the MMA established a floor of 1.0 on adjustments to the physician work relative value unit for the GPCI for the years 2004 through 2006. Section 602 of the MMA increased the GPCIs for work, PE, and malpractice in Alaska to 1.67. We estimate that sections 412 and 602 of the MMA increased 2004 Medicare spending included in the SGR by 0.6 percent. Sections 303 and 304 of the MMA increased Medicare's payments for drug administration in 2004. It further exempted the increases in payment from the budget neutrality provisions of section 1848(c)(2) of the Act. We estimate the section 303 and 304 provisions increased spending for physicians' services by 1.0 percent in 2004. Taken together, we estimate that statutory provisions increased 2004 spending for physicians' services by 1.7 percent (after accounting for rounding).

VIII. Anesthesia and Physician Fee Schedule Conversion Factors (CF) for CY 2006

The 2006 PFS CF will be $36.1770. The 2006 national average anesthesia CF is $16.9591.

A. Physician Fee Schedule Conversion Factor

Under section 1848(d)(1)(A) of the Act, the PFS CF is equal to the CF for the previous year multiplied by the update determined under section 1848(d)(4) of the Act.

Under section 1848(c)(2) of the Act, adjustments to RVUs may not cause the amount of expenditures to differ by more than $20 million from the amount of expenditures that would have resulted without such adjustments. As described earlier, we are implementing several changes to the work RVUs that would result in a change in expenditures that would exceed $20 million if we made no offsetting adjustments to either the conversion factor or RVUs.

With respect to the work RVUs, our policy has been to meet the budget-neutrality requirements in the statute by making an adjustment to the conversion factor. That is, we estimate the aggregate number of work RVUs that will be paid under current and revised policy in CY 2006. We apply a uniform adjustment factor to the conversion factor to make the aggregate payments under the revised work RVUs equal the aggregate payments under the current work RVUs. As a result of the 2006 work RVU changes described earlier, we will be making an adjustment of .9985 percent to the conversion factor to meet the budget neutrality requirements in the statute. Note that this adjustment is also being applied to the anesthesia fee schedule as shown in table 46.

We illustrate the calculation for the 2006 PFS CF in Table 45.

TABLE 45

2005 Conversion Factor	$37.8975.
2006 Update	−4.4 percent.
2006 Adjustment for Work RVU Changes.	.9985.
2006 Conversion Factor	$36.1770.

B. Anesthesia Fee Schedule Conversion Factor

Anesthesia services do not have RVUs like other PFS services. Therefore, we account for any necessary RVU adjustments through an adjustment to the anesthesia fee schedule CF to simulate changes to RVUs. We modeled the resource-based practice expense methodology using imputed anesthesia RVUs that were made comparable to other physician fee schedule services. As a result of modeling practice expense changes, we are incorporating a 1.00039 adjustment to the anesthesia fee schedule conversion factor. We used the following figures to determine the anesthesia fee schedule CF (see Table 46).

TABLE 46

2005 Anesthesia Conversion Factor	$17.7594.
2006 Update	−4.4 percent.
2006 Adjustment for Work RVU Changes	.9985.
2006 Adjustment for PE Changes	1.00039.
2006 Anesthesia Conversion Factor	$16.9591.

IX. Telehealth Originating Site Facility Fee Payment Amount Update

Section 1834(m) of the Act establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001 through December 31 2002, at $20. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased by the percentage increase in the MEI as defined in section 1842(i)(3) of the Act. The MEI increase for 2006 is 2.8 percent.

Therefore, for CY 2006, the payment amount for HCPCS code ''Q3014, telehealth originating site facility fee'' is 80 percent of the lesser of the actual charge or $22.47. The Medicare telehealth originating site facility fee and MEI increase by the applicable time period is shown in Table 47.

TABLE 47

Facility fee	MEI increase (percent)	Period
$20.00	N/A	10/01/2001–12/31/2002
$20.60	3.0	01/01/2003–12/31/2003
$21.20	2.9	01/01/2004–12/31/2004
$21.86	3.1	01/01/2005–12/31/2005
$22.47	2.8	01/01/2006–12/31/2006

X. Provisions of the Final Rule With Comment

The provisions of this final rule with comment restate the provisions of the August 2005 proposed rule, except as noted elsewhere in the preamble.

XI. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposed rule. The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed, and the terms and substances of the proposed rule or a description of the subjects and issues involved. This procedure can be waived, however, if an agency finds good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued.

As discussed in sections III. and V. of this final rule with comment, we utilize HCPCS codes for Medicare payment purposes. The HCPCS is a national drug coding system comprised of Level I (CPT) codes and Level II (HCPCS National Codes) that are intended to provide uniformity to coding procedures, services, and supplies across all types of medical providers and suppliers. Level I (CPT) codes are copyrighted by the AMA and consist of several categories, including Category I codes which are 5-digit numeric codes, and Category III codes which are temporary codes to track emerging technology, services and procedures.

The AMA issues an annual update of the CPT code set each Fall, with January 1 as the effective date for implementing the updated CPT codes. The HCPCS, including both Level I and Level II codes, is similarly updated annually on a CY basis. Annual coding changes are not available to the public until the Fall immediately preceding the annual January update of the PFS. Because of the timing of the release of these new codes, it is impracticable for CMS to provide prior notice and solicit comment on these codes and the RVUs assigned to them in advance of publication of the final rule that implements the PFS. Yet, it is imperative that these coding changes be accounted for and recognized timely under the PFS for payment because services represented by these codes will be provided to Medicare beneficiaries by physicians during the CY in which they become effective. Moreover, regulations implementing HIPAA (42 CFR parts 160 and 162) reguire that the HCPCS be used to report health care services, including services paid under the PFS. We also assign interim RVUs to any new codes based on a review of the RUC recommendations for valuing these services. By reviewing these RUC recommendations for the new codes, we are able to assign RVUs to services based on input from the medical community and to establish payment for them, on an interim basis, that corresponds to the relative resources associated with providing the services. If we did not assign RVUs to new codes on an interim basis, the alternative would be to either not pay for these services during the initial CY or have each carrier establish a payment rate for these new codes. We believe both of these alternatives are contrary to the public interest, particularly since the RUC process allows for an assessment of the valuation of these services by the medical community prior to our establishing payment for these codes on an interim basis. Therefore, we believe it would be contrary to the public interest to delay establishment of fee schedule payment amounts for these codes.

For the reasons outlined above, we find good cause to waive the notice of proposed rulemaking for the interim RVUs for selected procedure codes identified in Addendum C and to establish RVUs for these codes on an interim final basis. We are providing a 60-day public comment period.

XII. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-

day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements:

Section 413.180 Procedures for Requesting Exceptions to Payment Rates

Paragraph (b) specifies the criteria for a pediatric ESRD facility requesting an exception to payment rates.

Paragraph (e) outlines the documentation that a pediatric ESRD facility must submit to CMS when requesting an exception to its payment rates. Paragraph (i) discusses the period of approval for payment exception requests. A prospective exception payment rate approved by CMS applies for the period from the date the complete exception request was filed with its intermediary until thirty days after the intermediary's receipt of the facility's letter notifying the intermediary of the facility's request to give up its exception rate.

The burden associated with the requirements in paragraph (e) is the time and effort required by the facility to prepare and submit the exception request to CMS. The burden associated with the requirement in paragraph (i) is the time and effort required by the facility to draft and mail the letter that notifies the intermediary of the facilities request to give up its exception rate.

The collection requirement in this section has not changed. While this requirement is subject to the PRA, this requirement is currently approved in OMB No. 0938–0296.

Section 413.184 Payment Exception: Pediatric Patient Mix

Paragraph (b) specifies the documentation requirements that a pediatric ESRD facility must meet in order to qualify for an exception to its prospective payment rate based on its pediatric patient mix. In addition to the other qualifications specified in this section, this section states that a facility must submit a listing of all outpatient dialysis patients (including all home patients) treated during the most recently completed and filed cost report.

The burden associated with this requirement is the time and effort for the facility to submit a listing of all outpatient dialysis patients (including all home patients) treated during the most recently completed and filed cost report.

The collection requirement in this section has not changed. While this requirement is subject to the PRA, this requirement is currently approved in OMB No. 0938–0296.

Section 413.186 Payment Exception: Self-Dialysis Training Costs in Pediatric Facilities

In summary, this section outlines the requirements a pediatric ESRD facility must meet to qualify for an exception to the prospective payment rate based on self-dialysis training costs. Paragraph (e) states that a facility must provide specific information to support its exception request. Paragraph (f) states that in addition to the other qualifications outlined in this section, pediatric ESRD facility must submit with its exception request a list of patients, by modality, trained during the most recent cost report period, in order to justify its accelerated training exception request.

The burden associated with these requirements is the time and effort for the facility to prepare and submit the required information to support its exception request, and the time and effort for the pediatric ESRD facility to prepare and submit with its exception request a list of patients, by modality, trained during the most recent cost report period.

The collection requirements in this section have not changed. While these requirements are subject to the PRA, they are currently approved in OMB No.0938–0296.

Section 414.804 Basis of Payment

In summary, this section requires manufacturers to report ASP data to CMS. This section details the process a manufacturer must follow to calculate the ASP. The ASP reporting requirements are discussed in further detail in the interim final rule with comment, Medicare Program; Manufacturer Submission of Manufacturer's Average Sales Price (ASP) Data for Medicare Part B Drugs and Biologicals, that published on April 2, 2004 in the **Federal Register** (69FR17935–17941).

The burden associated with these requirements is the time and effort required by manufacturers of Medicare Part B Drugs and biologicals to prepare and submit to the required ASP data to CMS.

While these requirements are subject to the PRA, the requirements are currently approved in OMB No. 0938–0921, with a current expiration date of September 30, 2007.

We intend to revise this information collection to include adequate instructions for manufacturers to report the ASP, the WAC, and other data elements. These revisions will be addressed in detail in a revised information collection request in accordance with the Paperwork Reduction Act of 1995.

We have submitted a copy of this proposed rule to OMB for its review of the information collection requirements described above. These requirements are not effective until they have been approved by OMB.

If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following:

Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Regulations Development Group, Attn: Jim Wickliffe, [CMS–1502–P], Room C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850; and

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Brenda Aguilar, CMS Desk Officer, CMS–1502–P, *Brenda.Aguilar@omb.eop.gov.* Fax (202) 395–6974.

XIII. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

XIV. Regulatory Impact Analysis

We have examined the impact of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980 Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded

Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibilities of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis must be prepared for final rules with economically significant effects (that is, a final rule that would have an annual effect on the economy of $100 million or more in any one year, or would adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities). As indicated in more detail below, we estimate that the PFS provisions included in this final rule with comment will redistribute more than $100 million in one year. We are considering this final rule with comment to be economically significant because its provisions are estimated to result in an increase, decrease or aggregate redistribution of Medicare spending that will exceed $100 million. Therefore, this final rule with comment is a major rule and we have prepared a regulatory impact analysis.

The RFA requires that we analyze regulatory options for small businesses and other entities. We prepare a regulatory flexibility analysis unless we certify that a rule would not have a significant economic impact on a substantial number of small entities. The analysis must include a justification concerning the reason action is being taken, the kinds and number of small entities the rule affects, and an explanation of any meaningful options that achieve the objectives with less significant adverse economic impact on the small entities.

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any rule that may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside a Metropolitan Statistical Area and has fewer than 100 beds. We have determined that this final rule with comment would have minimal impact on small hospitals located in rural areas. Of 227 hospital-based ESRD facilities located in rural areas, only 40 are affiliated with hospitals with fewer than 100 beds.

For purposes of the RFA, physicians, nonphysician practitioners, and suppliers are considered small businesses if they generate revenues of $6 million or less. Approximately 95 percent of physicians are considered to be small entities. There are about 875,000 physicians, other practitioners and medical suppliers that receive Medicare payment under the PFS.

For purposes of the RFA, approximately 90 percent of suppliers of durable medical equipment (DME) and prosthetic devices are considered small businesses according to the Small Business Administration's (SBA) size standards. We estimate that 106,000 entities bill Medicare for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) each year. Total annual estimated Medicare revenues for DME suppliers exceed approximately $8.5 billion in 2004. Of this amount, approximately $1.4 billion were for nebulizer drugs in 2004. The vast majority, 95 percent, of retail pharmacy companies are small businesses as measured by the SBA size standard. Approximately, 16,000 pharmacies billed Medicare for immunosuppressive, oral anti-cancer, or oral anti-emetic drugs in 2004. Pharmacies received Medicare revenues for those drugs of approximately $350 million in 2004.

In addition, most ESRD facilities are considered small entities, either based on nonprofit status or by having revenues of $29 million or less in any year. We consider a substantial number of entities to be affected if the final rule is estimated to impact more than 5 percent of the total number of small entities. Based on our analysis of the 957 nonprofit ESRD facilities considered small entities in accordance with the above definitions, we estimate that the combined impact of the changes to payment for renal dialysis services included in this final rule with comment would have a 1.5 percent decrease in payments relative to current payments.

The impact of the CAP provisions included in this final rule with comment on an individual physician is dependent on whether the drugs they provide to Medicare beneficiaries are included in the list of CAP drugs and whether the physician chooses to obtain drugs administered to Medicare beneficiaries through the CAP.

In addition, the CAP provisions in this rule will have a potential impact on entities, either existing or formed specifically for this purpose, that are involved in the dispensing or distribution of drugs. The impact is dependent on the ability of potential vendors to successfully compete on a national level and receive approval as a vendor under the CAP.

The analysis and discussion provided in this section, as well as elsewhere in this final rule with comment, complies with the RFA requirements.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditures in any year by State, local, or tribal governments, in the aggregate, or by the private sector, of $120 million. Medicare beneficiaries are considered to be part of the private sector for this purpose.

We have examined this final rule with comment in accordance with Executive Order 13132 and have determined that this regulation would not have any significant impact on the rights, roles, or responsibilities of State, local, or tribal governments. A discussion concerning the impact of this rule on beneficiaries is found later in this section.

We have prepared the following analysis, which, together with the information provided in the rest of this preamble, meets all assessment requirements. It explains the rationale for and purposes of the rule; details the costs and benefits of the rule; analyzes alternatives; and presents the measures we plan to use to minimize the burden on small entities. As indicated elsewhere in this final rule with comment, we are making a variety of changes to our regulations, payments, or payment policies to ensure that our payment systems reflect changes in medical practice and the relative value of services. We provide information for each of the policy changes in the relevant sections of this final rule with comment. We are unaware of any relevant Federal rules that duplicate, overlap or conflict with this rule. The relevant sections of this final rule with comment contain a description of significant alternatives if applicable.

A. Resource-Based Work and PE RVUs

Under section 1848(c)(2) of the Act, adjustments to RVUs may not cause the amount of expenditures to differ by more than $20 million from the amount of expenditures that would have resulted without such adjustments. We are implementing several changes that would result in a change in expenditures that would exceed $20 million if we made no offsetting adjustments to either the CF or RVUs.

With respect to the work RVUs, our policy has been to meet the budget-neutrality requirements in the statute by

making an adjustment to the CF. That is, we estimate the aggregate number of work RVUs that will be paid under current and revised policy in CY 2006. We apply a uniform adjustment factor to the CF to make the aggregate payments under the revised work RVUs equal the aggregate payments under the current work RVUs. As a result of the 2006 work RVU changes described earlier, we will be making an adjustment of −0.6 percent to the CF to meet the budget neutrality requirements in the statute.

For PE RVUs, our policy has been to meet the budget-neutrality requirements in the statute by incorporating a rescaling adjustment in the PE methodologies. That is, we estimate the aggregate number of PE RVUs that will be paid under current and revised policy in CY 2006. We apply a uniform adjustment factor to make the aggregate number of revised PE RVUs equal the number estimated that would be paid under current policy. While we are continuing to apply this policy for general changes in coding and RVUs, we are increasing aggregate PFS payments to account for the higher payments for drug administration services resulting from the incorporation of the survey data submitted by the AUA. These increases in payment are being made under the authority of section 1848(c)(2)(J) of the Act that exempts the changes in payments for drug administration from the budget neutrality requirements of section 1848(c)(2)(B)(iv) of the Act.

As described earlier, we will base PE payments in 2006 on the current 2005 PE RVUs to the extent practicable after making changes required by law, such as the incorporation of the urology survey for the drug administration codes. In the situation where a code is new in 2006 and we do not have 2005 PE RVUs, we created new PE RVUs to use as the basis for 2006 payments. Table 49, Impact of CY 2006 RVU Changes, Multiple Imaging Discount, and Conversion Factor Update on Total Medicare Allowed Charges by Specialty, shows the percentage impact by specialty of the PE changes in combination with other changes being implemented.

The −4 percent decrease in payment for clinical psychology shown in the PE refinements column in Table 49 is attributable to the deletion of several codes and creation of new codes for certain psychological testing services. The deleted codes had reflected the practitioner's work in the PE RVUs. As indicated in Table 29 of section III.D., we accepted the recommendation of the RUC's HCPAC for work RVUs for the new codes. Thus, there is a shift in payment from the PE RVUs to the work RVUs for these psychological testing codes. We note that the increase in the payment in the work RVUs exceeds the decrease in payment in the PE RVUs, causing an overall net increase in payments to clinical psychologists of 2 percent as a result of the shift from the PE RVUs to the work RVUs for these new codes. While not included in table 49, we estimate that temporary payment associated with IVIG described previously will result in approximately $10 million in additional CY 2006 allowed charges under the PFS.

B. Malpractice RVUs

As discussed in section II C. of this final rule with comment, we are making technical changes to the calculation of the malpractice RVUs. We are removing the malpractice data for specialties that occur less than 5 percent of the time in our data for a procedure code; adopting several changes to the crosswalks used to assign risk factors to specialties for which we did not otherwise have data; using the lowest risk factor of 1.00 for clinical psychology, licensed clinical social work, chiropractors, and physical therapists; and adding cardiology catheterization and angioplasty codes to the list of codes for which we apply surgical rather than nonsurgical risk adjustment factors. Table 49 shows the combined impact of these changes. The impact of these methodological changes in the calculation of resource-based malpractice expense RVUs is negligible as malpractice RVUs account for less than 4 percent of total payments.

C. Multiple Imaging Procedures

As discussed in section II.J of this final rule with comment, we are reducing payments for TCs of certain multiple imaging procedures performed in the same session within the same imaging families. In order to calculate the impact of this change, we examined 2004 PFS carrier claims processed through March 31, 2005. We extracted all claims that were billed on the same day, for the same beneficiary, at the same provider, for multiple diagnostic imaging procedures within the same family of codes. For each subset of claims, the procedures were arrayed based on the pricing of the TC of these services. In the proposed rule, we simulated the effect of the multiple procedure payment reduction by accounting for 100 percent of the highest priced TC, and 50 percent of all other TCs. In this final rule with comment, we simulated the effect of the multiple procedure payment reduction by accounting for 100 percent of the highest priced TC, and 25 percent of all other TCs. This change is the result of public comments described more fully in section II.J. of this rule. Note that if the procedure was billed globally, the professional component was always calculated at 100 percent of the professional component (modifier-26) value.

The simulated total allowed charges for each family of codes includes all global, technical, and professional utilization for the family of codes (for example, the sum of claims where the multiple procedure payment reduction would have been in effect, in addition to claims that would not have been subject to the multiple procedure payment reduction). These simulated totals were then compared to the actual allowed charges for each family of codes within the same time period to calculate the impacts of the change.

Table 48 shows the actual 2004 allowed charges by family of imaging procedures and lists the percentage impact by family if this policy had been in effect. Family 2 has the largest −9.5 percent impact, while Family 11 has the smallest −0.7 percent impact.

TABLE 48.—IMPACT OF MULTIPLE PROCEDURE REDUCTION FOR DIAGNOSTIC IMAGING BY FAMILY OF IMAGING SERVICES

Family	Description of family of imaging procedures	2004 Medicare allowed charges ($ in millions)	Percentage impact
01	Ultrasound (Chest/Abdomen/Pelvis—Non-Obstetrical)	$138	−3.4
02	CT and CTA (Chest/Thorax/Abd/Pelvis)	563	−9.5
03	CT and CTA (Head/Brain/Orbit/Maxillofacial/Neck)	97	−1.3
04	MRI and MRA (Chest/Abd/Pelvis)	105	−2.4
05	MRI and MRA (Head/Brain/Neck)	532	−3.1

TABLE 48.—IMPACT OF MULTIPLE PROCEDURE REDUCTION FOR DIAGNOSTIC IMAGING BY FAMILY OF IMAGING SERVICES—Continued

Family	Description of family of imaging procedures	2004 Medicare allowed charges ($ in millions)	Percentage impact
06	MRI and MRA (spine)	540	−2.2
07	CT (spine)	24	−2.1
08	MRI and MRA (lower extremities)	166	−1.6
09	CT and CTA (lower extremities)	5	−1.0
10	MR and MRI (upper extremities and joints)	107	−1.4
11	CT and CTA (upper extremities)	2	−0.7
	Total for all procedures subject to multiple imaging reductions	2,276	−4.2

Using the same data, we also summarized the dollar value of the reductions by specialty. Specialty-specific percentage impacts were calculated by comparing each specialty's 2004 allowed charges for all Medicare allowed services to the reduced allowed charges that would have occurred had this policy been in effect. As expected, the most significant impacts occur among radiologists, who would experience a −1 percent impact. Diagnostic testing facilities also experience a −1 percent impact. Most other specialties experience a very small (0.1 percent) payment increase as a result of the budget neutrality adjustment. (Because this multiple procedure reduction adjustment would otherwise reduce overall payments by 0.1 percent, it is necessary to include a budget neutrality adjustment to the PE RVUs, resulting in positive impacts for most specialties.) Table 49 shows the percentage impact by specialty in combination with other changes being implemented.

D. Combined Impacts

Our estimates of changes in Medicare revenues for PFS services compare payment rates for 2006 with payment rates for 2005 using 2004 Medicare utilization for both years. We are using 2004 Medicare claims processed and paid through June 30, 2005, that we estimate are 98.5 percent complete, and have adjusted the figures to reflect a full year of data. Thus, because we are using a single year of utilization, the estimated changes in revenues reflect payment changes only between 2005 and 2006. To the extent that there are year-to-year changes in the volume and mix of services provided by physicians, the actual impact on total Medicare revenues will be different than those shown here. The payment impacts reflect averages for each specialty based on Medicare utilization. The payment impact for an individual physician would be different from the average, based on the mix of services the physician provides. The average change in total revenues would be less than the impact displayed here because physicians furnish services to both Medicare and non-Medicare patients and specialties may receive substantial Medicare revenues for services that are not paid under the PFS. For instance, independent laboratories receive approximately 80 percent of their Medicare revenues from clinical laboratory services that are not paid under the PFS. Table 49 shows only the payment impact on PFS services.

Table 49 shows the specialty level impact on payment of the work RVU changes, practice expense RVU changes, malpractice RVU changes, and multiple imaging payment changes being implemented for CY 2006. The column labeled ''Final Rule Impacts'' shows the combined effect of the changes in payment attributable to the work RVU changes, practice expense RVUs, malpractice RVUs, and the multiple imaging policy. The column labeled ''Impact of Update and Drug Admin. Transition shows the impact of these changes, and reflects the expiration of the transitional adjustment required by section 303 of the MMA for drug administration services. This adjustment was set at 32 percent for 2004 and 3 percent for 2005. In addition, this column reflects a −4.4 percent payment update to the CF described in section VI. of this final rule with comment and the budget neutrality scaler required by the changes in the work RVUs.

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TABLE 49: Impact of CY 2006 RVU Changes, Multiple Imaging Discount, and Conversion Factor Update on Total Medicare Allowed Charges by Specialty

Specialty	Medicare Allowed Charges ($ million)	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of Malpractice RVU Changes	Impact of Multiple Imaging Discount	Combined Impact[1]	Impact of Update and Drug Admin. Transition[1, 2]
Physicians:							
Allergy/Immunology	170	0%	0%	0%	0%	0%	-4%
Anesthesiology	1,500	0%	0%	0%	0%	0%	-5%
Cardiac Surgery	390	0%	0%	0%	0%	0%	-5%
Cardiology	7,290	0%	0%	0%	0%	0%	-4%
Colon and Rectal Surgery	120	0%	0%	0%	0%	1%	-4%
Critical Care	150	0%	0%	0%	0%	0%	-4%
Dermatology	2,050	0%	0%	0%	0%	0%	-5%
Emergency Medicine	1,870	0%	0%	0%	0%	0%	-4%
Endocrinology	300	0%	0%	0%	0%	0%	-4%
Family Practice	4,740	0%	0%	0%	0%	0%	-4%
Gastroenterology	1,720	0%	0%	0%	0%	0%	-4%
General Practice	1,050	0%	0%	0%	0%	1%	-4%
General Surgery	2,350	0%	0%	0%	0%	1%	-4%
Geriatrics	120	1%	0%	0%	0%	2%	-3%
Hand Surgery	70	0%	0%	0%	0%	0%	-5%
Hematology/Oncology	1,790	0%	0%	0%	0%	0%	-6%
Infectious Disease	440	0%	0%	0%	0%	0%	-4%
Internal Medicine	9,440	0%	0%	0%	0%	0%	-4%
Interventional Radiology	210	0%	0%	0%	0%	-1%	-5%
Nephrology	1,530	0%	0%	0%	0%	0%	-4%
Neurology	1,300	0%	0%	0%	0%	0%	-4%
Neurosurgery	550	0%	0%	0%	0%	0%	-4%
Nuclear Medicine	90	0%	0%	0%	0%	0%	-5%

Specialty	Medicare Allowed Charges ($ million)	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of Malpractice RVU Changes	Impact of Multiple Imaging Discount	Combined Impact[1]	Impact of Update and Drug Admin. Transition[1, 2]
Obstetrics/Gynecology	620	0%	0%	0%	0%	0%	-5%
Ophthalmology	4,770	0%	0%	0%	0%	0%	-5%
Orthopedic Surgery	3,180	0%	0%	0%	0%	0%	-5%
Otolaryngology	880	0%	0%	0%	0%	0%	-5%
Pathology	930	0%	0%	0%	0%	0%	-4%
Pediatrics	70	0%	0%	0%	0%	0%	-4%
Physical Medicine	760	0%	0%	0%	0%	0%	-4%
Plastic Surgery	280	0%	0%	0%	0%	0%	-4%
Psychiatry	1,150	0%	0%	0%	0%	0%	-4%
Pulmonary Disease	1,540	0%	0%	0%	0%	0%	-4%
Radiation Oncology	1,330	0%	0%	0%	0%	0%	-5%
Radiology	5,200	0%	0%	0%	-1%	-1%	-6%
Rheumatology	450	0%	0%	0%	0%	0%	-5%
Thoracic Surgery	470	0%	0%	0%	0%	0%	-5%
Urology	1,830	0%	1%	0%	0%	1%	-4%
Vascular Surgery	570	0%	0%	0%	0%	0%	-4%
Practitioners:							
Audiologist	30	0%	0%	0%	0%	0%	-5%
Chiropractor	730	0%	0%	-1%	0%	-1%	-5%
Clinical Psychologist[3]	540	7%	-4%	-1%	0%	2%	-3%
Clinical Social Worker	350	0%	0%	0%	0%	0%	-5%
Nurse Anesthetist	530	0%	0%	0%	0%	0%	-5%
Nurse Practitioner	630	1%	0%	0%	0%	2%	-3%
Optometry	730	0%	0%	0%	0%	0%	-4%
Oral/Maxillofacial Surgery	40	0%	0%	0%	0%	0%	-5%
Physical/Occupational Therapy	1,310	0%	0%	0%	0%	0%	-5%
Physicians Assistant	480	0%	0%	0%	0%	0%	-4%
Podiatry	1,510	0%	0%	0%	0%	1%	-4%
Suppliers:							
Diagnostic Testing Facility	1,100	0%	0%	0%	-1%	-2%	-6%

Specialty	Medicare Allowed Charges ($ million)	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of Malpractice RVU Changes	Impact of Multiple Imaging Discount	Combined Impact[1]	Impact of Update and Drug Admin. Transition[1,2]
Independent Laboratory	640	0%	0%	0%	0%	0%	-4%
Portable X-Ray Supplier	100	0%	0%	0%	0%	0%	-4%

[1] Totals may not sum due to rounding.
[2] Includes a 0.9984 scaler resulting from the addition of new WRVUs from the annual CPT update process.
[3] The +7 percent work impact and the -4 percent practice expense impact are associated with the removal of the clinical psychologist time from the practice expense inputs and the inclusion of this time in the work relative value unit.

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Table 50 shows the impact on total payments for selected high-volume procedures of all of the changes previously discussed. We selected these procedures because they are the most commonly provided by a broad spectrum of physician specialties. There are separate columns that show the change in the facility rates and the nonfacility rates. For an explanation of facility and nonfacility PE refer to section II.A. in the preamble of this final rule with comment.

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TABLE 50: Impact of Final Rule with Comment on Medicare Payment for Selected Procedures

CPT / HCPCS	MOD	Description	Non-Facility			Facility		
			Old	New	Percent Change	Old	New	Percent Change
11721		Debride nail, 6 or more	$39.79	$37.99	-4.5	$31.08	$29.67	-4.5
17000		Destroy benign/premlg lesion	$60.64	$57.88	-4.5	$44.34	$42.33	-4.5
27130		Total hip arthroplasty	NA	NA	NA	$1,396.14	$1,334.21	-4.4
27244		Treat thigh fracture	NA	NA	NA	$1,134.65	$1,084.22	-4.4
27447		Total knee arthroplasty	NA	NA	NA	$1,507.94	$1,440.93	-4.4
33533		CABG, arterial, single	NA	NA	NA	$1,923.30	$1,837.79	-4.4
35301		Rechanneling of artery	NA	NA	NA	$1,128.59	$1,078.07	-4.5
43239		Upper GI endoscopy, biopsy	$333.50	$319.08	-4.3	$162.20	$154.84	-4.5
66821		After cataract laser surgery	$248.23	$237.32	-4.4	$230.42	$220.32	-4.4
66984		Cataract surg w/iol, 1 stage	NA	NA	NA	$684.05	$653.72	-4.4
67210		Treatment of retinal lesion	$599.54	$573.04	-4.4	$573.39	$548.08	-4.4
71010		Chest x-ray	$28.04	$26.77	-4.5	NA	NA	NA
71010	26	Chest x-ray	$9.47	$9.04	-4.5	$9.47	$9.04	-4.5
76091		Mammogram, both breasts	$97.40	$92.97	-4.5	NA	NA	NA
76091	26	Mammogram, both breasts	$45.10	$43.05	-4.5	$45.10	$43.05	-4.5
76092		Mammogram, screening	$85.65	$81.76	-4.5	NA	NA	NA
76092	26	Mammogram, screening	$36.38	$34.73	-4.5	$36.38	$34.73	-4.5
77427		Radiation tx management, x5	$172.05	$164.24	-4.5	$172.05	$164.24	-4.5
78465	26	Heart image (3d), multiple	$77.31	$73.80	-4.5	$77.31	$73.80	-4.5
88305	26	Tissue exam by pathologist	$42.07	$40.16	-4.5	$42.07	$40.16	-4.5
90801		Psy dx interview	$153.11	$146.16	-4.5	$144.01	$137.47	-4.5
90862		Medication management	$51.92	$49.56	-4.5	$48.89	$46.67	-4.5
90935		Hemodialysis, one evaluation	NA	NA	NA	$73.14	$69.82	-4.5
92012		Eye exam established pat	$65.18	$62.22	-4.5	$37.14	$35.45	-4.5
92014		Eye exam & treatment	$96.26	$91.89	-4.5	$60.64	$57.88	-4.5
92980		Insert intracoronary stent	NA	NA	NA	$809.11	$773.10	-4.5
93000		Electrocardiogram, complete	$26.91	$25.69	-4.5	NA	NA	NA
93010		Electrocardiogram report	$9.10	$8.68	-4.5	$9.10	$8.68	-4.5
93015		Cardiovascular stress test	$108.01	$103.10	-4.5	NA	NA	NA

CPT / HCPCS	MOD	Description	Non-Facility			Facility		
			Old	New	Percent Change	Old	New	Percent Change
93307	26	Echo exam of heart	$49.27	$47.03	-4.5	$49.27	$47.03	-4.5
93510	26	Left heart catheterization	$257.32	$246.00	-4.4	$257.32	$246.00	-4.4
98941		Chiropractic manipulation	$36.76	$35.09	-4.5	$31.83	$30.39	-4.5
99203		Office/outpatient visit, new	$97.02	$92.61	-4.5	$72.38	$69.10	-4.5
99213		Office/outpatient visit, est	$52.68	$50.29	-4.5	$35.62	$34.01	-4.5
99214		Office/outpatient visit, est	$82.62	$78.87	-4.5	$59.12	$56.44	-4.5
99222		Initial hospital care	NA	NA	NA	$112.93	$107.81	-4.5
99223		Initial hospital care	NA	NA	NA	$157.27	$150.13	-4.5
99231		Subsequent hospital care	NA	NA	NA	$34.11	$32.56	-4.5
99232		Subsequent hospital care	NA	NA	NA	$55.71	$53.18	-4.5
99233		Subsequent hospital care	NA	NA	NA	$79.21	$75.61	-4.5
99236		Observ/hosp same date	NA	NA	NA	$223.22	$213.08	-4.5
99239		Hospital discharge day	NA	NA	NA	$96.64	$92.25	-4.5
99243		Office consultation	$122.79	$117.21	-4.5	$93.99	$89.72	-4.5
99244		Office consultation	$172.81	$165.33	-4.3	$138.70	$132.41	-4.5
99253		Initial inpatient consult	NA	NA	NA	$ 98.91	$94.42	-4.5
99254		Initial inpatient consult	NA	NA	NA	$142.12	$135.66	-4.5
99283		Emergency dept visit	NA	NA	NA	$62.15	$59.33	-4.5
99284		Emergency dept visit	NA	NA	NA	$97.02	$92.61	-4.5
99291		Critical care, first hour	$256.57	$245.28	-4.4	$207.68	$198.25	-4.5
99292		Critical care, addl 30 min	$113.69	$108.53	-4.5	$103.84	$99.12	-4.5
99348		Home visit, est patient	$72.01	$68.74	-4.5	NA	NA	NA
99350		Home visit, est patient	$164.48	$157.01	-4.5	NA	NA	NA
G0008		Admin influenza virus vac	$18.57	$17.73	-4.5	NA	NA	NA
G0317		ESRD related svs 4+mo 20+yrs	$307.73	$294.12	-4.4	$307.73	$294.12	-4.4
G0344		Initial preventive exam	$97.40	$92.97	-4.5	$72.76	$69.46	-4.5
G0366		EKG for initial prevent exam	$26.91	$25.69	-4.5	NA	NA	NA
G0367		EKG tracing for initial prev	$17.81	$17.00	-4.5	NA	NA	NA
G0368		EKG interpret & report preve	$9.10	$8.68	-4.5	$9.10	$8.68	-4.5

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In the CY 2005 final rule, we showed the combined impact of PFS and drug payment changes on the total revenues for specialties that perform a significant volume of drug administration services. (69 FR 66406) Although we have not performed a similar combined impact analysis this year for all of the specialties considered last year, we have undertaken a similar analysis of hematology/oncology. In last year's final rule, we announced a 1 year demonstration to collect information about symptoms for cancer patients receiving chemotherapy (69 FR 66308). In this final rule with comment, we are announcing a new demonstration project again focused on improving the quality of care provided to beneficiaries stricken with cancer. Although both of these demonstrations are implemented through the Secretary's authority under sections 402(a)(1)(B) and 402(b) of the Social Security Act Amendments of 1967 (Pub. L. 90–248), we discussed the impacts of the additional payments from the 2005 demonstration in last year's final rule impact analysis. Therefore, we are also including an analysis of the

impact on payments to oncologists as the 2005 demonstration project ends and the new demonstration project begins.

We have updated the analysis from the proposed rule using more recent data. As indicated in Table 51, PFS services account for approximately 25 percent of Medicare revenues for oncologists. The current demonstration accounts for approximately 3 percent of Medicare revenues for oncologists. If we assume no growth in the volume of PFS services, the combined 2006 impact of changes in Medicare payments for all PFS and demonstration services provided by oncologists is –10 percent.

We estimate that approximately 70 percent of total Medicare revenues for oncologists are attributed to drugs. If we again assume no growth in the volume of PFS services and additionally assume no growth in Medicare Part B drug spending (price or volume), we project total Medicare revenues to oncologists would decline by –3 percent.

If we assume historical growth for the volume of PFS services and continue to assume no growth in Medicare Part B drug spending, we estimate total Medicare revenues to oncologists would remain unchanged between 2005 and 2006.

If we assure historical growth for the volume of PFS services and for the volume of Medicare Part B drugs, we estimate total Medicare revenues to oncologists would increase by 6 percent between 2005 and 2006.

We estimate that the revised chemotherapy demonstration project discussed earlier will result in additional allowed charges to oncologists of approximately $150 million in CY 2006.

TABLE 51: Impact of Physician Fee Schedule, Demonstration, and Drug Payment Changes on Total Oncology Medicare Payments

Physician Fee Schedule and Demonstrations			Drugs		*All Revenues*	
% of Total Medicare Revenues from Fee Schedule	% of Total Medicare Revenues from the 2005 Demo.	% Change Medicare Physician Fee Schedule and Demo. Revenues	% of Total Medicare Revenues from Drugs	% Change Medicare Drug Revenues	Combined % Change All Medicare Revenues before growth*	*Combined % Change All Medicare Revenues after growth* **
25%	3%	-10%	70%	0%	-3%	0%

*Note: Reflects changes in total Medicare revenues assuming no changes in utilization. Calculation reflects average changes in fee schedule payments and for drugs weighted by percent of Medicare revenues. No change is assumed in the relatively small Medicare revenues outside of the fee schedule and drugs.

** Note: We estimate that Medicare payments to oncologists would increase by 8% between 2005 and 2006 if growth in the volume of physician fee schedule services were to grow at historical rates, despite the effect of the end of the 1 year demonstration project. This estimate assumes no growth in the volume of drug revenue.

E. Medicare Telehealth Services

In section II.D. of this final rule with comment, we are adding individual medical nutrition therapy, as represented by HCPCS codes G0270, 97802, and 97803, to the list of telehealth services. We believe that this change will have little effect on Medicare expenditures.

F. Contractor Pricing of CPT Codes 97039 and 97139

As discussed earlier in the preamble of this final rule with comment (section II.E.), we will have the contractors value CPT codes 97039 and 97139. This will make the pricing methodology for these services consistent with our policy for other unlisted services and should not have a significant impact on Medicare expenditures.

G. ESRD–MMA Related Provisions

The ESRD related provisions in this final rule with comment are discussed in section II.G. To understand the impact of the changes affecting payments to different categories of ESRD facilities, it is necessary to compare estimated payments under the current payment system (current payments) to estimated payments under the revisions to the composite rate payment system as set forth in this final rule with comment (final payments). To estimate the impact among various classes of ESRD facilities, it is imperative that the estimates of current payments and final payments contain similar inputs. Therefore, we simulated payments only for those ESRD facilities for which we are able to calculate both current 2005 payments and final 2006 payments.

Due to data limitations, we are unable to estimate current and final payments for 171 facilities that bill for ESRD dialysis treatments. ESRD providers were grouped into the categories based on characteristics provided in the Online Survey and Certification and Reporting (OSCAR) file and the most recent cost report data from the Healthcare Cost Report Information System (HCRIS). We also used the June 2005 update of CY 2004 Standard Analytical File (SAF) claims as a basis for Medicare dialysis treatments and separately billable drugs and biologicals. As we stated in the proposed rule, this is an updated version of the 2004 SAF file compared to the December 2004 version of the file we used in the proposed rule.

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Table 52: Impact of CY 2006 Changes in Payments to Hospital Based and Independent ESRD Facilities (Includes Drug and Composite Rate Payments) [Percent change in total payments to ESRD facilities (both program and beneficiaries)]

(1)	Number of Facilities (2)	Number of Dialysis Treatments (in millions) (3)	Effect of Changes in Wage Index[1/] (4)	Effect of Changes in Drug Payments[2/] (5)	Overall Effect[3/] (6)
All Facilities	4,393	33.3	0.0	2.9	1.2
By Facility Type:					
Independent	3,762	29.3	-0.1	4.7	1.9
Hospital-Based	631	4.0	0.4	-9.2	-3.8
By Facility Size:					
Less than 5,000 treatments	1,575	4.5	-0.2	2.7	1.0
5,000 to 9999 treatments	1,703	12.5	0.0	3.4	1.4
Greater than 9, 999 treatments	1,115	16.4	0.1	2.5	1.1
By Type of Ownership:					
Profit	3,436	26.7	-0.1	4.6	1.9
Nonprofit	957	6.6	0.2	-3.9	-1.5
By Geographic Location:					
Rural	1,218	6.8	-0.2	2.5	1.0
Urban	3,175	26.6	0.0	2.9	1.2
By Region:					
New England	144	1.2	1.3	3.9	2.3
Middle Atlantic	552	4.5	0.6	-1.1	-0.1
East North Central	671	5.1	-0.7	3.1	0.8
West North Central	344	1.8	-0.4	2.3	0.7
South Atlantic	988	7.6	0.0	2.9	1.3
East South Central	346	2.5	-0.5	3.6	1.3
West South Central	592	4.6	-0.4	4.0	1.4
Mountain	233	1.5	-0.2	4.4	1.5
Pacific	492	4.1	0.8	5.0	2.4
Puerto Rico	31	0.4	-0.5	6.1	2.0

1/ This column shows the effect of wage changes to composite rate payments to ESRD providers. Composite rate payments computed using the current wage index are compared to composite rate payments using the CY 2006 wage index changes.

2/ This column shows the effect of the changes in drug payments to ESRD providers. These include CY 2006 changes in payment for separately billable drugs (2006 ASP+6) and the 14.7% drug add-on compared to current payment for separately billable drugs (2005 AAP) and the current 8.7% drug add-on. We did not have data for hospital-based utilization of top ten drugs other than EPO. Therefore, we used a proxy to estimate CY 2006 payments to hospital-based ESRD facilities for top ten drugs other than EPO. We estimated these drugs by using the spread of ASP+6 to AWP from independent facilities and applying it to payments to hospital-based facilities for drugs other than EPO.

3/ This column shows the percent change between CY 2006 and CY 2005 total payments to ESRD facilities. The CY 2006 payments include the CY 2006 wage adjusted composite rate, and the 14.7% drug add-on times treatments plus CY 2006 payment for separately billable drugs (2006 ASP+6). The CY 2005 payment to ESRD facilities includes the current wage adjusted composite rate and the 8.7% drug add on times treatments plus current drug payments for separately billable drugs (2005 AAP).

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Table 52 shows the impact of CY 2006 changes to payments to hospital based and independent ESRD facilities. We have included both composite rate payments as well as payments for separately billable drugs and biologicals because both are affected by the CY 2006 changes. The first column of Table 52 identifies the type of ESRD provider, the second column indicates the number of ESRD facilities for each type, and the third column indicates the number of dialysis treatments.

The fourth column shows the effect of changes to the ESRD wage index as it affects the composite rate payments to ESRD facilities. Composite rate

payments account for about 60 percent of revenues to ESRD facilities. The fourth column compares aggregate wage adjusted composite rate payments using the revised ESRD wage index compared to the current ESRD wage adjusted composite rate payments. Since CY 2006 is the first year of the 4-year transition to the revised ESRD wage index, ESRD facilities receive 25 percent of the revised CBSA-based wage adjusted composite rate and 75 percent of the current composite rate. The overall effect to all ESRD providers in aggregate is zero because the CY 2006 ESRD wage index has been multiplied by a BNF to comply with the statutory requirement that any wage index revisions be done in a manner that results in the same aggregate amount of expenditures as would have been made without any changes in the wage index. The percent changes shown in the fifth and sixth columns are the result of the increase to the drug add-on and the changes in drug prices which are explained in section XIV.G. of this final rule with comment.

The fifth column shows the effect of the changes in drug payments to ESRD providers between CY 2006 and CY 2005. Drug payments account for about 40 percent of revenues to ESRD providers. Current payments for drugs represent 2005 Medicare reimbursement using AAP prices for the top ten drugs (as discussed earlier in this preamble). Current Medicare spending for the top ten drugs is estimated using 2005 AAP prices times actual drug utilization from 2004 claims. (EPO units are estimated using payments because the units field on bills represents the number of EPO administrations rather than the number of EPO units). Spending for CY 2006 is estimated by using the average of the four quarters of 2005 ASP +6 percent for the top ten drugs times actual drug utilization from 2004 claims. The prices for these top ten drugs are discussed earlier in this preamble and the average of the four quarters of 2005 are shown in Table 52. We did not have hospital-based facilities utilization data for top ten drugs other than EPO. Therefore, we needed a proxy to estimate CY 2006 payments to hospital-based facilities under ASP +6 pricing. We estimated these drugs by using the weighted spread of the difference between ASP +6 and AWP prices from independent facilities and applying it to payments to hospital-based facilities for top ten drugs other than EPO.

Payment for drugs in 2006 also includes the 14.7 percent drug add-on to the composite rate. This amount is computed by multiplying the wage adjusted composite rate for each provider and the dialysis treatments from 2004 claims. Column 5 is computed by comparing spending under the CY 2006 payment for drugs (4 quarter average of 2005 ASP +6) including the 14.7 percent drug add-on amount to spending under current payments for drugs with the current drug add-on of 8.7 percent.

We did not simulate any case mix in this impact table (Table 52) because 2004 claims data do not include the new data fields (height and weight) that are needed to calculate case mix. These data fields were not required to be reported by providers until January 1, 2005. However, we have not made any changes to case mix for CY 2006.

Column 6 shows the overall effect of all changes in drug and composite rate payments to ESRD providers. The overall effect is measured as the difference between CY 2006 payment with all MMA changes in this final rule with comment and current payment. CY 2006 payment is computed by multiplying the composite rate for each provider (with both the CY 2006 ESRD wage index and the 14.7 percent drug add-on) times dialysis treatments from 2004. In addition, the CY 2006 payment includes payments for separately billable drugs under the ASP +6 drug pricing using a 4 quarter average of 2005 ASP +6. Current payment is the current wage adjusted composite rate for each provider times dialysis treatments from 2004 claims plus current AAP priced drug payments for separately billable drugs with the current 8.7 percent drug add-on.

The overall impact on ESRD providers in the aggregate is 1.2 percent increase. At first it may not seem obvious how the growth rates in columns 4 and 5 combine to result in the overall growth effect in column 6. While the wage index changes are budget neutral in aggregate, the drug payments to all ESRD providers have increased by 2.9 percent. Since drug payments to ESRD providers account for about 40 percent of revenues and the composite payment rate payment account for the other 60 percent of revenues, the 2.9 percent growth in drugs combined with the budget neutral composite rate payments result in the overall 1.2 percent growth in payment to all ESRD providers.

Some commenters expressed concern regarding the reduction in payment rates for dialysis facilities in certain States and requested that we provide a State-specific impact analysis. Table 53 lists the impact for each State.

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TABLE 53: Change in CY 2006 ESRD Composite Rate Payments Based on New Wage Adjusted Composite Rate (with 4-year Transition) Compared to Current Wage Adjusted Composite Rate

State	Number of Providers	Percent Impact
AK	4	-0.3%
AL	107	-0.6%
AR	57	-0.9%
AZ	89	-0.2%
CA	377	0.8%
CO	43	-0.5%
CT	30	1.5%
DC	20	0.0%
DE	15	0.6%
FL	262	0.0%
GA	213	0.3%
HI	18	0.3%
IA	52	-0.6%
ID	7	0.1%
IL	165	-0.5%
IN	92	-0.4%
KS	43	-0.9%
KY	59	-0.6%
LA	136	-0.8%
MA	68	1.2%
MD	109	-0.3%
ME	17	0.6%
MI	136	-1.0%
MN	75	1.0%
MO	108	-0.9%
MS	67	-0.6%
MT	15	-0.4%
NC	139	0.1%
ND	13	-1.1%
NE	32	0.1%
NH	10	1.7%
NJ	120	1.7%
NM	29	-0.3%
NV	22	0.5%
NY	218	0.9%
OH	187	-1.3%
OK	59	-1.1%
OR	43	0.7%
PA	215	-0.8%
PR	31	-0.5%
RI	15	1.5%
SC	88	0.1%
SD	21	-0.2%
TN	114	-0.4%
TX	343	-0.2%
UT	21	-0.1%
VA	123	-0.2%
VT	7	0.7%
WA	52	1.4%
WI	97	0.3%
WV	23	-0.9%
WY	8	-0.7%
All States		0.0%

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H. Payment for Covered Outpatient Drugs and Biologicals, and CAP Provisions

As discussed in section II.H of this final rule with comment, the changes to the supplying fee for immunosuppressive, oral anticancer, and oral anti-emetic drugs are estimated to reduce total Federal expenditures by $2 million in 2006, and $14 million over the 5-year period, CY 2006 to 2010. The changes to the inhalation drug dispensing fee are expected to reduce total Federal expenditures by $120 million in 2006, and $720 million over the 5-year period, CY 2006 to 2010.

For the CAP provisions contained in this final rule with comment, the purpose of the CAP program is to provide choices to physicians and potentially achieve budgetary savings to Medicare and beneficiaries through a competitive bidding approach to determining Medicare payment rates for selected drugs. In addition the CAP will provide physicians with an alternative way to obtain these selected drugs that they use for treating their Medicare beneficiaries in their offices. As discussed in the July 6, 2005 interim final rule (70 FR 39091), we have estimated the impact of the costs of furnishing or administering drugs through the CAP on the Medicare program and expect it to be negligible, at the beginning until participating CAP physicians, approved CAP vendors and CMS gain more experience with the program. During the first year, we anticipate no significant additional cost savings or increases associated with the CAP, relative to the ASP payment system. The CAP program will provide alternatives to physicians who do not wish to purchase drugs directly or collect coinsurance.

I. Private Contracts and Opt-Out Provision

The changes discussed in section II.I. of this final rule with comment, with respect to private contracts and the opt-out provision, are estimated to have no significant impact on Medicare expenditures. However, we believe the changes will clarify that the consequences for the failure to maintain opt-out will apply regardless of whether the physician or practitioner was notified by the carrier.

J. FQHC Supplemental Payment Provision

Section 237 of the MMA amended section 1833(a)(3) of Act to provide supplemental payments to FQHCs that contract with Medicare Advantage (MA) organizations to cover the difference, if any, between the payment received by the health center for treating MA enrollees and the payment to which the FQHC would be entitled to receive under its cost-based all-inclusive payment rate. We estimate that this new MMA payment provision for FQHC services will not increase Medicare payments. In other words, this MMA provision will have no budgetary impact on the Medicare trust fund due to the fact that a supplemental payment will only be made when the MA payment to the health center is less than its original FQHC cost based rate. Consequently, no additional Medicare expenditures will be needed to pay the center up to what it would have received under original Medicare.

K. National Coverage Decisions Timeframes

The changes to § 426.340 discussed in section II.N. of this final rule with comment, are made in order to conform certain timeframes in the regulation to meet legislative changes made by the MMA of 2003. These changes to the regulation meet Congressional intent in the development of NCDs, and conform the regulation to the overall NCD process. There are no budget implications as a result of these changes.

L. Coverage of Screening for Glaucoma

As discussed in section II.O. of the preamble to this final rule with comment, we are expanding the definition of an eligible beneficiary under the glaucoma screening benefit to include Hispanic Americans age 65 and over, effective January 1, 2006, subject to certain frequency and other limitations on coverage. At present, § 410.23(a)(2) (Conditions for and limitations on coverage of screening for glaucoma) defines the term ''eligible beneficiary'' to include individuals in the following high risk categories:

- Individual with diabetes mellitus.
- Individual with a family history of glaucoma.
- African-Americans age 50 and over.

Based on the projected utilization of these screening services and related medically necessary follow-up tests and treatment that may be required for the additional beneficiaries screened, we estimate that this expanded benefit will result in an increase in Medicare payments to ophthalmologists or optometrists who will provide these screening tests and related follow-up tests and treatment. However, as discussed in earlier in section II.O. this is not expected to have a significant cost impact on the Medicare program.

M. Physician Referral for Nuclear Medicine Services

As discussed earlier in section V., we are revising the regulations at 411.351 to include all diagnostic and therapeutic nuclear medicine services and supplies furnished or referred on or after January 1, 2007, in the definitions of ''radiology and certain other imaging services'' and ''radiation therapy services and supplies,'' respectively.

As stated in the proposed rule, the inclusion of nuclear medicine as a designated health service (DHS) primarily would affect physicians and health care entities that furnish these types of items and services to Medicare beneficiaries. We are unable to quantify the number of physicians who have either an ownership or an investment interest in entities that furnish nuclear medicine services and/or supplies. Even if we assume that a substantial number of physicians have ownership or investment interests in these types of entities, we believe that, in general, the economic impact on these physicians would not necessarily be substantial, for the reasons stated below.

Physician owners/investors of entities that furnish nuclear medicine services and supplies in a manner that satisfies the requirements of the in-office ancillary services exception would not be affected by this proposed rule. Similarly, a physician's ownership of, or investment in, a rural provider of nuclear medicine services and supplies would not be affected by this rule if the financial relationship complies with the rural provider exception at § 411.356(c)(1), which allows a physician to own and refer to an entity at least 75 percent of all DHS that it furnishes to residents of a rural area, as defined in the physician self-referral statute. We also do not know the extent to which equipment (such as a PET scanner) that was purchased by an entity in which a physician has an ownership or investment interest will be fully depreciated (or mostly so) or functionally obsolete by the time this rule is effective.

Although the impact on an individual physician may be significant, we do not believe that physicians, in general, will be significantly affected if they are required to stop making referrals to an entity in which they have an ownership interest. We believe that the majority of physicians receive most of their income from the services they personally provide, and not from nuclear medicine services performed by entities that they own or invest in. In addition, we assume that, unless the physician established the entity to serve only his

or her patients, the entity receives referrals from other physicians. Thus, the physician may still receive a return on the ownership or investment. Likewise, we do not believe that a physician's divestiture of his or her ownership interest would necessarily have a significant economic effect. We assume, that, from an economic standpoint, most physicians invest in entities because they are income producing. If an investment is successful, a physician should have little difficulty finding new investors willing to acquire the physician's investment. We are unable to quantify the number of physicians who would wish to divest his or her ownership interest as a result of this rule, nor are we able to ascertain the degree to which these physicians would sell their ownership interests at a loss or profit. We believe the cost of divestiture will vary from situation to situation. Also, since the rule is not effective until January 1, 2007, this will give those physicians who wish to divest additional time to find a suitable buyer and will allow those physicians an additional year in which to depreciate their nuclear medicine equipment.

We expect that this change may result in savings to both the Medicare and Medicaid programs by minimizing anti-competitive business arrangements as well as financial incentives that encourage over-utilization of costly nuclear medicine services. We cannot gauge with any certainty the extent of these savings to either program at this time.

N. Alternatives Considered

This final rule with comment contains a range of policies, including some which are related to specific MMA provisions. The preamble provides descriptions of the statutory provisions that are addressed, identifies those policies when discretion has been exercised, presents rationale for our decisions and, where relevant, alternatives that were considered.

We considered making our proposal to include diagnostic and therapeutic nuclear medicine services and supplies as a DHS effective immediately; however, we are persuaded that delaying the effective date until January 1, 2007 would be less disruptive to physicians who may choose to divest their investment and to beneficiaries who may need to receive services and supplies at another location.

O. Impact on Beneficiaries

There are a number of changes made in this final rule with comment that would have an effect on beneficiaries. In general, we believe these changes will improve beneficiary access to services that are currently covered or will expand the Medicare benefit package to include new services.

As explained in more detail below, the regulatory provisions may affect beneficiary liability in some cases. Any changes in aggregate beneficiary liability from a particular provision will be a function of the coinsurance (20 percent if applicable for the particular provision after the beneficiary has met the deductible) and the effect of the aggregate cost (savings) of the provision on the calculation of the Medicare Part B premium rate (generally 25 percent of the provision's cost or savings).

To illustrate this point, under this final rule with comment the 2006 national payment amount in the nonfacility setting for CPT code 99203, as shown in Table 50, is $92.61 which means that, in 2006, the beneficiary coinsurance for this service would be $18.52.

In addition, as with the 2005 chemotherapy demonstration project, the Medicare beneficiaries, or their supplemental insurers, who receive office-based cancer treatment, will be liable for the 20 percent Part B coinsurance on the G codes billed under the 2006 oncology demonstration. The service linking the payment of the demonstration fee has changed from a chemotherapy infusion or push service in 2005 to an established office visit of level 2, 3, 4, or 5 in 2006. The demonstration fee payment will be lower per unit of service for the Medicare beneficiary in 2006 than 2005 thus, we expect that the coinsurance liability for a Medicare beneficiary will be reduced. However, the total impact on a beneficiary will depend upon the specific services received during 2006.

Very few of the changes we are making impact overall payments and therefore will affect Medicare beneficiaries' coinsurance liability. Changes discussed above that do affect overall spending would similarly impact beneficiaries' coinsurance.

For example, we have tried to ensure that the rule concerning physician self-referral for nuclear medicine services would not adversely impact the medical care of Medicare or Medicaid patients. We recognize that our proposal may have an impact on current arrangements under which patients are receiving medical care, and that some financial arrangements may have to be restructured for patients to continue receiving medically necessary nuclear medicine services and supplies at the same location or from the same entity. Therefore, we are delaying the effective date of this provision until January 1, 2007. Implementation of this rule is consistent with the statutory intent of section 1877(h) of the Act. This final rule with comment may help minimize anti-competitive behavior that can affect where a beneficiary receives health care services. It may also reduce the potential for overutilization, and thus, decrease the number of unnecessary tests or procedures to which Medicare and Medicaid patients are subjected.

With respect to the CAP provisions, we do not expect, during the first year of the program, that there will be an appreciable difference to the beneficiaries if their drugs were to be administered by a physician participating in the CAP or purchasing them and being reimbursed for them within the ASP payment system. At least initially, until approved CAP vendors, participating CAP physicians, and CMS gain more experience with this new program, we do not anticipate there would be any significant additional costs or savings to a beneficiary whose physician participates in the CAP. The CAP should be largely transparent to the beneficiary population. The only change should be the entity that bills the beneficiary for the coinsurance.

We also do not believe that beneficiaries would experience drug access issues as a result of implementation of the CAP. However, we intend to monitor beneficiary access closely and may propose additional changes to our payment system in the future, if necessary.

P. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf*), in Table 54 we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this final rule with comment. Table 54 includes the impact of the changes in this rule on providers and suppliers and encompasses the −4.4 percent negative update to the PFS based on the statutory SGR formula.

Expenditures are classified as transfers to Medicare providers or suppliers (that is, ESRD facilities and physicians, other practitioners and medical suppliers, including CAP vendors, that receive payment under the PFS or Medicare Part B).

TABLE 54.—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES, FROM CY 2005 TO THE CY 2006

[In millions]

Category	Transfers
Annualized Monetized Transfers	Negative transfer—Estimated decrease in expenditures $2668.
From Whom To Whom?	Federal Government To ESRD Medicare Providers; physicians, other practitioners and suppliers, including CAP vendors that receive payment under the Medicare Physician Fee Schedule; and Medicare Suppliers billing for Part B drugs.

In accordance with the provisions of Executive Order 12866, this final rule with comment was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 405

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medical devices, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 410

Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 411

Kidney diseases, Medicare, Physician Referral, Reporting and record keeping requirements.

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 414

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 424

Emergency medical services, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 426

Administrative practice and procedure, Medicare, Reporting and recordkeeping requirements.

■ For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as set forth below:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

■ 1. The authority citation for part 405 continues to read as follows:

Authority: Secs. 1102, 1861, 1862(a), 1871, 1874, 1881, and 1886(k) of the Social Security Act (42 U.S.C. 1302, 1395x, 1395y(a), 1395hh, 1395kk, 1395rr, and 1395ww(k)), and sec. 353 of the Public Health Service Act (42 U.S.C. 263a).

Subpart D—Private Contracts

■ 2. Section 405.435 is amended by—

■ A. Revising paragraph (b) introductory text.

■ B. Adding paragraph (d).

The revision and addition read as follows:

§ 405.435 Failure to maintain opt-out.

* * * * *

(b) If a physician or practitioner fails to maintain opt-out in accordance with paragraph (a) of this section, then, for the remainder of the opt-out period, except as provided by paragraph (d) of this section—

* * * * *

(d) If a physician or practitioner demonstrates that he or she has taken good faith efforts to maintain opt-out (including by refunding amounts in excess of the charge limits to beneficiaries with whom he or she did not sign a private contract) within 45 days of a notice from the carrier of a violation of paragraph (a) of this section, then the requirements of paragraphs (b)(1) through (b)(8) of this section are not applicable. In situations where a violation of paragraph (a) of this section is not discovered by the carrier during the 2-year opt-out period when the violation actually occurred, then the requirements of paragraphs (b)(1) through (b)(8) of this section are applicable from the date that the first violation of paragraph (a) of this section occurred until the end of the opt-out period during which the violation occurred (unless the physician or practitioner takes good faith efforts, within 45 days of any notice from the carrier that the physician or practitioner failed to maintain opt-out, or within 45 days of the physician's or practitioner's discovery of the failure to maintain opt-out, whichever is earlier, to correct his or her violations of paragraph (a) of this section. Good faith efforts include, but are not limited to, refunding any amounts collected in excess of the charge limits to beneficiaries with whom he or she did not sign a private contract.

Subpart X—Rural Health Clinic and Federally Qualified Health Center Services

■ 3. Add § 405.2469 to read as follows:

§ 405.2469 Federally Qualified Health Centers supplemental payments.

Federally Qualified Health Centers under contract (directly or indirectly) with Medicare Advantage organizations are eligible for supplemental payments for covered Federally Qualified Health Center services furnished to enrollees in Medicare Advantage plans offered by the Medicare Advantage organization to cover the difference, if any, between their payments from the Medicare Advantage plan and what they would receive under the cost-based Federally Qualified Health Center payment system.

(a) *Calculation of supplemental payment.* (1) The supplemental payment for Federally Qualified Health Center covered services provided to Medicare patients enrolled in Medicare Advantage plans is based on —

(i) The difference between payments received by the center from the Medicare Advantage plan as determined on a per visit basis;

(ii) The Federally Qualified Health Center's all-inclusive cost-based per visit rate as set forth in this subpart;

(iii) Less any amount the FQHC may charge as described in section 1857(e)(3)(B) of the Act.

(2) Any financial incentives provided to Federally Qualified Health Centers under their Medicare Advantage contracts, such as risk pool payments, bonuses, or withholds, are prohibited from being included in the calculation of supplemental payments due to the Federally Qualified Health Center.

(b) *Per visit supplemental payment.* A supplemental payment required under this section is made to the Federally Qualified Health Center when a covered face-to-face encounter occurs between a Medicare Advantage enrollee and a practitioner as set forth in § 405.2463.

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

■ 4. The authority citation for part 410 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart B—Medical and Other Health Services

■ 5. Section 410.23 is amended by—
■ A. Revising paragraphs (a)(2)(i) through (iii).
■ B. Adding a new paragraph (a)(2)(iv).

The revision and addition read as follows:

§ 410.23 Screening for glaucoma: Conditions for and limitations on coverage.

(a) * * *

(2) * * *

(i) Individual with diabetes mellitus.

(ii) Individual with a family history of glaucoma.

(iii) African-Americans age 50 and over.

(iv) Hispanic-Americans age 65 and over.

* * * * *

■ 6. Section 410.78 is amended by—
■ A. Revising paragraph (b) introductory text.
■ B. Adding paragraph (b)(2)(viii).

The revision and addition read as follows:

§ 410.78 Telehealth services

* * * * *

(b) *General rule.* Medicare Part B pays for office and other outpatient visits, professional consultation, psychiatric diagnostic interview examination, individual psychotherapy, pharmacologic management, end stage renal disease related services included in the monthly capitation payment (except for one visit per month to examine the access site), and individual medical nutrition therapy furnished by an interactive telecommunications system if the following conditions are met:

* * * * *

(2) * * *

(viii) A registered dietitian or nutrition professional as described in § 410.134.

* * * * *

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

■ 7. The authority citation for part 411 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart J—Financial Relationships Between Physicians and Entities Furnishing Designated Health Services

■ 8. Section 411.351 is amended by —
■ A. Revising the definition of ''Radiation therapy services and supplies''.
■ B. Revising the definition of ''Radiology and certain other imaging services''.
■ C. Revising the introductory text of paragraph (2) of the definition of ''Referral''.

The revisions read as follows:

§ 411.351 Definitions.

* * * * *

Radiation therapy services and supplies means those particular services and supplies, including (effective January 1, 2007) therapeutic nuclear medicine services and supplies, so identified on the List of CPT/HCPCS Codes. All services and supplies so identified on the List of CPT/HCPCS Codes are radiation therapy services and supplies for purposes of this subpart. Any service or supply not specifically identified as radiation therapy services or supplies on the List of CPT/HCPCS Codes is not a radiation therapy service or supply for purposes of this subpart. The list of codes identifying radiation therapy services and supplies is based on section 1861(s)(4) of the Act and § 410.35 of this chapter.

Radiology and certain other imaging services means those particular services so identified on the List of CPT/HCPCS Codes. All services so identified on the List of CPT/HCPCS Codes are radiology and certain other imaging services for purposes of this subpart. Any service not specifically identified as radiology and certain other imaging services on the List of CPT/HCPCS Codes is not a radiology or certain other imaging service for purposes of this subpart. The list of codes identifying radiology and certain other imaging services includes the professional and technical components of any diagnostic test or procedure using x-rays, ultrasound, computerized axial tomography, magnetic resonance imaging, nuclear medicine (effective January 1, 2007), or other imaging services. All codes identified as radiology and certain other imaging services are covered under section 1861(s)(3) of the Act and § 410.32 and § 410.34 of this chapter, but do not include—

(1) X-ray, fluoroscopy, or ultrasound procedures that require the insertion of a needle, catheter, tube, or probe through the skin or into a body orifice; and

(2) Radiology procedures that are integral to the performance of a nonradiological medical procedure and performed—

(i) During the nonradiological medical procedure; or

(ii) Immediately following the nonradiological medical procedure when necessary to confirm placement of an item placed during the nonradiological medical procedure.

Referral—

* * * * *

(2) Does not include a request by a pathologist for clinical diagnostic laboratory tests and pathological examination services, by a radiologist for diagnostic radiology services, and by a radiation oncologist for radiation therapy or ancillary services necessary for, and integral to, the provision of radiation therapy, if—

* * * * *

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

■ 9. The authority citation for part 413 continues to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395D(D), 1395f(b), 1395g, 13951(a), (i), and (n), 1395hh, 1395rr, 1395tt, and 1395ww).

Subpart H—Payment for End-Stage Renal Disease (ESRD) Services and Organ Procurement Costs

■ 10. Section 413.170 is amended by revising paragraph (b) to read as follows:

§ 413.170 Scope.

* * * * *

(b) Providing procedures and criteria under which a pediatric ESRD facility (an ESRD facility with at least a 50 percent pediatric patient mix as specified in § 413.184 of this subpart) may receive an exception to the prospective payment rates; and

* * * * *

■ 11. Section 413.174 is amended by—
■ A. Revising paragraph (f).

■ B. Removing paragraph (g).

The revision reads as follows:

§ 413.174 Prospective rates for hospital-based and independent ESRD facilities.

* * * * *

(f) *Additional payment for separately billable drugs.* CMS makes an additional payment for certain drugs furnished to ESRD patients by a Medicare-approved ESRD facility. CMS makes this payment directly to the ESRD facility. Payment for these drugs is made—

(1) Only on an assignment basis, directly to the facility which must accept, as payment in full, the amount that CMS determines;

(2) Subject to the Part B deductible and coinsurance;

(3) Effective January 1, 2006, to hospital-based ESRD facilities in accordance with the methodology specified in § 414.904 of this subchapter.

(4) To independent ESRD facilities in accordance with the methodology specified in § 405.517 of this subchapter.

■ 12. Section 413.180 is amended by—

■ A. Revising paragraphs (b) and (d)

■ B. Removing paragraphs (e) and (k).

■ C. Redesignating paragraphs (f) through (j) as paragraphs (e) through (i).

■ D. Revising newly redesignated paragraph (i).

■ E. Redesignating paragraphs (l) and (m) as paragraphs (j) and (k).

■ F. Revising newly redesignated paragraph (k).

The revisions read as follows:

§ 413.180 Procedures for requesting exceptions to payment rates.

* * * * *

(b) *Criteria for requesting an exception.* If a pediatric ESRD facility projects on the basis of prior year costs and utilization trends that it has an allowable cost per treatment higher than its prospective rate set under § 413.174, and if these excess costs are attributable to one or more of the factors in § 413.182, the facility may request, in accordance with paragraph (e) of this section, that CMS approve an exception to that rate and set a higher prospective payment rate.

* * * * *

(d) *Payment rate exception request.* Effective October 1, 2002, CMS may approve exceptions to a pediatric ESRD facility's updated prospective payment rate, if the pediatric ESRD facility did not have an approved exception rate as of October 1, 2002. A pediatric ESRD facility may request an exception to its payment rate at any time after it is in operation for at least 12 consecutive months.

* * * * *

(i) *Period of approval: Payment exception request.* A prospective exception payment rate approved by CMS applies for the period from the date the complete exception request was filed with its intermediary until 30 days after the intermediary's receipt of the facility's letter notifying the intermediary of the facility's request to give up its exception rate and be subject to the basic case-mix adjusted composite payment rate methodology. ESRD facilities electing to retain their nonpediatric or pediatric exception rates (including self-dialysis training) do not need to notify their intermediaries. Once a facility notifies its fiscal intermediary in writing that it cannot retain its current exception rate, that decision cannot be subsequently reversed.

* * * * *

(k) *Criteria for refiling a denied exception request.* A pediatric ESRD facility that was denied an exception request may immediately file another exception request. Any subsequent exception request must address and document the issues cited in CMS' denial letter.

■ 13. Section 413.182 is revised to read as follows:

§ 413.182 Criteria for approval of exception requests.

(a) CMS may approve exceptions to a pediatric ESRD facility's prospective payment rate if the pediatric ESRD facility did not have an approved exception rate as of October 1, 2002.

(b) The pediatric ESRD facility must demonstrate, by convincing objective evidence, that its total per treatment costs are reasonable and allowable under the relevant cost reimbursement principles of part 413 and that its per treatment costs in excess of its payment rate are directly attributable to any of the following criteria:

(1) Pediatric patient mix, as specified in § 413.184.

(2) Self-dialysis training costs in pediatric facilities, as specified in § 413.186.

■ 14. Section 413.184 is amended by revising paragraphs (a) and (b)(1) to read as follows:

§ 413.184 Payment exception: Pediatric patient mix.

(a) *Qualifications.* To qualify for an exception to its prospective payment rate based on its pediatric patient mix a facility must demonstrate that—

(1) At least 50 percent of its patients are individuals under 18 years of age;

(2) Its nursing personnel costs are allocated properly between each mode of care;

(3) The additional nursing hours per treatment are not the result of an excess number of employees;

(4) Its pediatric patients require a significantly higher staff-to-patient ratio than typical adult patients; and

(5) These services, procedures, or supplies and their per treatment costs are clearly prudent and reasonable when compared to those of pediatric facilities with a similar patient mix.

(b) *Documentation.* (1) A pediatric ESRD facility must submit a listing of all outpatient dialysis patients (including all home patients) treated during the most recently completed and filed cost report (in accordance with cost reporting requirements under § 413.198) showing—

(i) Age of patients and percentage of patients under the age of 18;

(ii) Individual patient diagnosis;

(iii) Home patients and ages;

(iv) In-facility patients, staff-assisted, or self-dialysis;

(v) Diabetic patients; and

(vi) Patients isolated because of contagious disease.

* * * * *

§ 413.186 [Removed]

■ 15. Section 413.186 is removed.

§ 413.188 [Removed]

■ 16. Section 413.188 is removed.

§ 414.190 [Redesignated as § 413.186]

■ 17. Redesignate § 413.190 as § 413.186 and revise the newly designated § 413.186 to read as follows:

§ 413.186 Payment exception: Self-dialysis training costs in pediatric facilities.

(a) *Qualification.* To qualify for an exception to the prospective payment rate based on self-dialysis training costs, the pediatric ESRD facility must establish that it incurs per treatment costs for furnishing self-dialysis and home dialysis training that exceed the facility's payment rate for the training sessions.

(b) *Justification.* To justify its exception request, a facility must—

(1) Separately identify those elements contributing to its costs in excess of the composite training rate; and

(2) Demonstrate that its per treatment costs are reasonable and allowable.

(c) *Criteria for determining proper cost reporting.* CMS considers the pediatric ESRD facility's total costs, cost finding and apportionment, including its allocation of costs, to determine if costs are properly reported by treatment modality.

(d) *Limitation of exception requests.* Exception requests for a higher training rate are limited to those cost

components relating to training such as technical staff, medical supplies, and the special costs of education (manuals and education materials). These requests may include overhead and other indirect costs to the extent that these costs are directly attributable to the additional training costs.

(e) *Documentation.* The pediatric ESRD facility must provide the following information to support its exception request:

(1) A copy of the facility's training program.

(2) Computation of the facility's cost per treatment for maintenance sessions and training sessions including an explanation of the cost difference between the two modalities.

(3) Class size and patients' training schedules.

(4) Number of training sessions required, by treatment modality, to train patients.

(5) Number of patients trained for the current year and the prior 2 years on a monthly basis.

(6) Projection for the next 12 months of future training candidates.

(7) The number and qualifications of staff at training sessions.

(f) *Accelerated training exception.* (1) A pediatric ESRD facility may bill Medicare for a dialysis training session only when a patient receives a dialysis treatment (normally 3 times a week for hemodialysis). Continuous cycling peritoneal dialysis (CCPD) and continuous ambulatory peritoneal dialysis (CAPD) are daily treatment modalities; ESRD facilities are paid the equivalent of three hemodialysis treatments for each week that CCPD and CAPD treatments are provided.

(2) If a pediatric ESRD facility elects to train all its patients using a particular treatment modality more often than during each dialysis treatment and, as a result, the number of billable training dialysis sessions is less than the number of actual training sessions, the facility may request a composite rate exception, limited to the lesser of the—

(i) Facility's projected training cost per treatment; or

(ii) Cost per treatment the facility receives in training a patient if it had trained patients only during a dialysis treatment, that is, three times per week.

(3) An ESRD facility may bill a maximum of 25 training sessions per patient for hemodialysis training and 15 sessions for CCPD and CAPD training.

(4) In computing the payment amount under an accelerated training exception, CMS uses a minimum number of training sessions per patient (15 for hemodialysis and 5 for CAPD and CCPD) when the facility actually provides fewer than the minimum number of training sessions.

(5) To justify an accelerated training exception request, an ESRD facility must document that a significant number of training sessions for a particular modality are provided during a shorter but more condensed period.

(6) The facility must submit with the exception request a list of patients, by modality, trained during the most recent cost report period. The list must include each beneficiary's—

(i) Name;

(ii) Age; and

(iii) Training status (completed, not completed, being retrained, or in the process of being trained).

(7) The total treatments from the patient list must be the same as the total treatments reported on the cost report filed with the request.

§ 413.192 [Removed]

■ 18. Section 413.192 is removed.

PART 414—PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES

■ 19. The authority citation for part 414 continues to read as follows:

Authority: Secs. 1102, 1871, and 1881(b)(1) of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395rr(b)(1)).

Subpart B—Physicians and Other Practitioners

■ 20. Section 414.65 is amended by revising paragraph (a)(1) to read as follows:.

§ 414.65 Payment for telehealth services

(a) * * *

(1) The Medicare payment amount for office or other outpatient visits, consultation, individual psychotherapy, psychiatric diagnostic interview examination, pharmacologic management, end stage renal disease related services included in the monthly capitation payment (except for one visit per month to examine the access site), and individual medical nutrition therapy furnished via an interactive telecommunications system is equal to the current fee schedule amount applicable for the service of the physician or practitioner.

* * * * *

Subpart J—Submission of Manufacture's Average Sales Price Data

■ 21. Section 414.804(a) is amended by revising paragraph (a)(3)(iv) to read as follows:

§ 414.804 Basis of payment.

(a) * * *

(3) * * *

(iv) *Example.* The total lagged price concessions (discounts, rebates, etc.) over the most recent 12-month period available associated with direct sales for National Drug Code 12345–6789–01 subject to the ASP reporting requirement equal $200,000. The total in dollars for the sales subject to the average sales price reporting requirement for the same period equals $600,000. The lagged price concessions percentage for this period equals 200,000/600,000 = .33333. The total in dollars for the direct sales subject to the average sales price reporting requirement for the quarter being reported equals $50,000 for 10,000 units sold. Assuming no non-lagged price concessions apply, the manufacturer's average sales price calculation for this National Drug Code for this quarter is: $\$50{,}000 - (0.33333 \times \$50{,}000) = \$33{,}334$ (net total sales amount); $33,334/10,000 = $3.33 (average sales price).

* * * * *

■ 22. Section 414.904 is amended by—

■ A. Revising paragraph (a) introductory text.

■ B. Adding a new paragraph (d)(2)(iii).

■ C. Revising paragraphs (d)(3) and (e)(2).

The revisions and additions read as follows:

§ 414.904 Basis of payment

(a) *Method of payment.* Payment for a drug furnished on or after January 1, 2005 is based on the lesser of—

* * * * *

(d) * * *

(2) * * *

(iii) Effective for drugs and biologicals furnished in 2006, the payment for such drugs and biologicals furnished in connection with renal dialysis services and separately billed by freestanding and hospital-based renal dialysis facilities not paid on a cost basis is 106 percent of the average sales price.

(3) *Widely available market price and average manufacturer price.* If the Inspector General finds that the average sales price exceeds the widely available market price or the average manufacturer price by 5 percent or more in calendar year 2006, the payment limit in the quarter following the transmittal of this information to the Secretary is the lesser of the widely available market price or 103 percent of the average manufacturer price.

(e) * * *

(2) *Infusion drugs furnished through a covered item of durable medical equipment.* The payment limit for an

infusion drug furnished through a covered item of durable medical equipment is calculated using 95 percent of the average wholesale price in effect on October 1, 2003 and is not updated in 2006.

* * * * *

■ 23. Section 414.906 is amended by revising paragraph (f) to read as follows:

§ 414.906 Competitive acquisition program as the basis for payment.

* * * * *

(f) *Substitution or addition of drugs on an approved CAP vendor's CAP drug list.* (1) *Short-term substitution of a CAP drug.* On an occasional basis (for a period of time less than 2 weeks), an approved CAP vendor may agree to furnish a substitute NDC within a HCPCS code on the approved CAP vendor's CAP drug list if the approved CAP vendor—

(i) Is willing to accept the payment amount that was established for the HCPCS code under this section; and

(ii) Obtains the participating CAP physician's prior approval.

(2) *Long-term substitution or addition of a CAP drug.* An approved CAP vendor may submit a request, as specified in paragraph (f)(3) of this section, for approval to substitute an NDC supplied by the approved CAP vendor for another NDC within the same HCPCS code or to add an NDC to the approved CAP vendor's drug list, if at least one of the following criteria is met:

(i) Proposed substitution of an NDC for a period of 2 weeks or longer.

(ii) Proposed addition of one or more NDCs within a HCPCS code included in the CAP drug category specified by CMS or on the approved CAP vendor's approved CAP drug list.

(iii) Proposed addition of—

(A) One or more newly issued HCPCS codes; or

(B) One of the following single indication orphan drug J codes or their updates: J0205, J0256, J9300, J1785, J2355, J3240, J7513, J9010, J9015, J9017, J9160, J9216.

(iv) Beginning January 1, 2007, the proposed addition of a drug(s) that has not yet been assigned a HCPCS code, but for which a HCPCS code must be established.

(3) *Requesting the addition or substitution of CAP drug.* An approved CAP vendor that meets the one of the criteria specified in paragraph (f)(2) must submit a written request to CMS or its designee. The request must—

(i) Specify the NDC(s) and the respective HCPCS code that is to be added or substituted.

(ii) Address the rationale for the substitution or addition of the NDC(s) or the addition of the HCPCS code(s) as applicable; and

(iii) Address the impact of the substitution of the NDC(s) or the addition of the NDC(s) or HCPCS code(s), or both on—

(A) Patient and drug safety;

(B) Drug waste; and

(C) The potential for cost savings.

(4) *Approval of a request(s).* CMS or its designee notifies the approved CAP vendor of its decision.

(i) Except as specified in paragraph (f)(4)(ii) of this section, an approved request is effective at the beginning of the next calendar quarter.

(ii) Approved substitutions for request based on a drug shortage or other exigent circumstance may become effective immediately provided that—

(A) CMS approves the immediate substitution; and

(B) The approved CAP vendor's notifies its CAP participating physicians of the substitution immediately following CMS approval.

(5) *Payment for an approved drug change(s).* The payment for— (i) Substituted or added CAP drugs that are within a HCPCS code for which payment is computed under paragraph (c)(1) of this section is the single payment for that HCPCS code, as determined and updated in accordance with paragraph (c)(1) of this section; or

(ii) Added CAP drugs that are not within a HCPCS code for which payment is computed under paragraph (c)(1) of this section is specified under paragraph (c)(2) of this section.

■ 24. Section 414.908 is amended by—

■ A. Revising paragraphs (a)(3)(v)(M).

■ B. Redesignating paragraphs (a)(3)(vi) through (a)(3) (xii) as (a)(3)(viii) through (a)(3)(xiv).

■ C. Adding new paragraphs (a)(3)(vi) and (a)(3)(vii).

■ D. Revising paragraph (a)(5).

The revisions and additions read as follows:

§ 414.908 Competitive acquisition program.

(a) * * *

(3) * * *

(v) * * *

(M) Additional patient information: date of birth, allergies, height/weight, ICD–9–CM (if necessary).

(vi) Agrees to accept the particular National Drug Codes (NDCs) supplied by the approved CAP vendor for the duration of the participating CAP physician's enrollment with the approved CAP vendor, subject to paragraphs (a)(3)(vii) and (a)(3)(xiv) of this section. By electing to participate with an approved CAP vendor, the participating CAP physician also agrees to accept the changes to the approved CAP vendor's CAP drug list that have been approved in accordance with § 414.906(f).

(vii) Agrees to place routine orders for CAP drugs at the HCPCs level, except when medical necessity requires a particular formulation on the approved CAP vendor's CAP drug list. Medical necessity must be documented. When the conditions of this paragraph are met, the participating CAP physician may submit a prescription order to the approved CAP vendor that specifies the NDC.

* * * * *

(5) *Additional opt out provision.* In addition to the circumstances listed in paragraph (a)(2) of this section, if the approved CAP vendor refuses to ship to the participating CAP physician because the conditions of § 414.914(h) were met, the physician can withdraw from the CAP category for the remainder of the year immediately upon notice to CMS and the approved CAP vendor.

* * * * *

■ 25. Section 414.914 is amended by—

■ A. Redesignating paragraphs (f)(9) through (f)(11) as paragraphs (f)(14) through (f)(16).

■ B. Redesignating (f)(5) through (f)(8) as paragraphs (f)(9) through (f)(12) and paragraphs.

■ C. Adding new paragraphs (f)(5) through (f)(8) and (f)(13).

■ D. Revising paragraph (g)(3).

■ E. Revising paragraphs (h)(1) through (h)(3), (h)(5) and (h)(6), and (h)(8).

The revisions and additions read as follows:

§ 414.914 Terms of contract.

* * * * *

(f) * * *

(5) Respond within 2 business days to any inquiry, or sooner if the inquiry is related to drug quality;

(6) Staff a toll-free telephone line from 8:30 a.m. or earlier and until 5 p.m. or later for all time zones served in the continental United States by the CAP vendor on business days (Monday through Friday excluding Federal holidays) to provide customer assistance, and establish reasonable hours of operation for Hawaii, Alaska, Puerto Rico, and the other U.S. territories;

(7) Staff an emergency toll-free telephone line for weekend and evening access when the call center is closed, and determine what hours on Saturday and Sunday the call center is staffed and which hours a toll-free emergency line is activated; and

(8) Include assistance for the disabled, the hearing impaired, and Spanish-

speaking inquirers in all customer service operations.

* * * * *

(13) Provide direct notification to participating CAP physicians enrolled with them of updates to the approved CAP vendor's CAP drug list on a quarterly basis. Changes must be disseminated at least 30 days before the approved changes are due to take effect, unless immediate notification as described in § 414.906(f)(4) is required. The approved CAP vendor's entire CAP drug list must be disseminated at least once yearly; and approved CAP vendors must make a complete list that incorporates the most recent updates available to physicians on an ongoing basis. CMS posts on its web site the updated CAP drug lists for each approved CAP vendor.

* * * * *

(g) * * *

(3) A full or partial waiver of the cost-sharing amount after determining in good faith that the individual is in financial need or the failure of reasonable collection efforts, provided that the waiver meets all of the requirements of section 1128A(i)(6)(A) of the Act and the corresponding regulations at paragraph (1) of the definition of ''Remuneration'' in § 1003.101 of this title. The availability of waivers may not be advertised or be made as part of a solicitation. Approved CAP vendors must inform beneficiaries that they generally make available the categories of assistance described in paragraphs (g)(1), (g)(2), and (g)(3) of this section. In no event may the approved CAP vendor include or make any statements or representations that promise or guarantee that beneficiaries receive cost-sharing waivers.

(h) * * *

(1) Subsequent to receipt of final payment by Medicare, or the verification of drug administration by the participating CAP physician, the approved CAP vendor must bill any applicable supplemental insurance policies.

(2) If a balance remains, after the supplemental insurer pays their share of the bill, or if there is no supplemental insurance, the approved CAP vendor may bill the beneficiary.

(3) At the time of billing the beneficiary, or the participating CAP physician's presentation of the bill on behalf of the approved CAP vendor, the approved CAP vendor must inform the beneficiary of any types of cost-sharing assistance that may be available consistent with the requirements of section 1128A(a)(5) of the Act and § 414.914(g).

(4) * * *

(5) For purposes of paragraph (h) delivery means postmark date, or the date the coinsurance bill or notice was presented to the beneficiary by the participating CAP physician on behalf of the approved CAP vendor.

(i) Except as specified in paragraph (h)(5)(ii), if after 45 days from delivery of the approved CAP vendor's bill to the beneficiary, the beneficiary's cost-sharing obligation remains unpaid, the approved CAP vendor may refuse further shipments to the participating CAP physician for that beneficiary.

(ii) If the beneficiary has requested cost-sharing assistance within 45 days of receiving delivery of the approved CAP vendor's bill, provisions of paragraphs (h)(6), (h)(7), or (h)(8) of this section, apply.

(6) If the approved CAP vendor implements a reasonable payment plan, as specified in § 414.914(g)(2), the approved CAP vendor must continue to ship CAP drugs for the beneficiary, as long as the beneficiary remains in compliance with the payment plan and makes an initial payment under the plan within 15 days after the delivery of the approved CAP vendor's written notice to the beneficiary offering the payment plan.

(7) * * *

(8) If the approved CAP vendor refers the beneficiary to a bona fide and independent charity in accordance with § 414.914(g)(1), the approved CAP vendor may refuse to ship drugs if the past due balance is not paid 15 days after the date of delivery of the approved CAP vendor's written notice to the beneficiary containing the referral for cost-sharing assistance.

* * * * *

Subpart L—Supplying and Dispensing Fees

■ 26. Section 414.1001 is revised to read as follows:

§ 414.1001 Basis of payment.

(a) *Supplying fees.* Beginning in CY 2006—

(1) A supplying fee of $24 is paid to a pharmacy for the first prescription of drugs and biologicals described in sections 1861(s)(2)(J), 1861(s)(2)(Q), and 1861(s)(2)(T) of the Act, that the pharmacy provided to a beneficiary during a 30-day period.

(2) A supplying fee of $16 is paid to a pharmacy for each prescription following the first prescription (as specified in paragraph (a)(1) of this section) of drugs and biologicals described in sections 1861(s)(2)(J), 1861(s)(2)(Q), and 1861(s)(2)(T) of the Act, that the pharmacy provided to a beneficiary during a 30-day period.

(3) A separate supplying fee is paid to a pharmacy for each prescription of drugs and biologicals described in sections 1861(s)(2)(J), 1861(s)(2)(Q), and 1861(s)(2)(T) of the Act.

(b) *Supplying fees following transplant.* Beginning CY 2006—(1) A supplying fee of $50 is paid to pharmacy for the initial supplied prescription of drugs and biologicals described in section 1861(s)(2)(J) of the Act, that the pharmacy provided to a patient during the first 30-day period following a transplant.

(2) A supplying fee of $16 is paid to a pharmacy for each prescription following an initial prescription after a transplant (as specified in paragraph (b)(1) of this section) of drugs and biologicals describe in section 1861(s)(2)(J) of the Act, that the pharmacy provided to a beneficiary during a 30-day period.

(c) *30-day dispensing fees.* Beginning CY 2006—(1) A dispensing fee of $57 is paid to a supplier to the extent that the prescription is for the initial dispensed 30-day supply of inhalation drugs furnished through durable medical equipment covered under section 1861(n) of the Act, regardless of the number of partial shipments of that 30-day supply.

(2) Except for supplied inhalation drugs that meet criteria described in paragraph (c)(1) of this section, a dispensing fee of $33 is paid for each dispensed 30-day supply of inhalation drugs furnished through durable medical equipment covered under section 1861(n) of the Act, regardless of the number of partial shipments of that 30-day supply.

(d) *90-day dispensing fee.* Beginning CY 2006, a dispensing fee of $66 is paid to a supplier for each dispensed 90-day supply of inhalation drugs furnished through durable medical equipment covered under section 1861(n) of the Act, regardless of the number of partial shipments of that 90-day supply.

PART 424—CONDITIONS FOR MEDICARE PAYMENT

■ 27. The authority citation for part 424 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

§ 424.22 [Amended]

■ 28. In § 424.22—

■ A. The footnote for paragraph (a)(1)(iv), the term ''hosptial'' is removed and the term ''hospital'' is added in its place.

■ B. Paragraph (d), remove the reference to ''§ 411.351'' and add in its place the reference ''§ 411.354''.

PART 426—REVIEW OF NATIONAL COVERAGE DETERMINATIONS AND LOCAL COVERAGE DETERMINATIONS

■ 29. The authority citation for part 426 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

■ 30. The heading for Part 426 is revised to read as set forth above.

Subpart C—General Provisions for the Review of LCDs and NCDs

■ 31. Section 426.340 is amended by revising paragraphs (e)(2) and (f)(2) to read as follows:

§ 426.340 Procedures for review of new evidence.

* * * * *

(e) * * *

(2) Sets a reasonable timeframe—

(i) For LCDs, of not more than 90 days, by which the contractor completes the reconsideration; or

(ii) For NCDs, in compliance with the timeframes specified in section 1862(1) of the Act, by which CMS completes the reconsideration.

(f) * * *

(2) Does not meet—

(i) For LCDs, the 90-day reconsideration timeframe; or

(ii) For NCDs, the reconsideration timeframe specified by the Board, in compliance with section 1862(1) of the Act.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: October 26, 2005.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Approved: November 1, 2005.

Michael O. Leavitt,

Secretary.

Note: These addenda will not appear in the Code of Federal Regulations.

Addendum A: Explanation and Use of Addenda B

The addenda on the following pages provides various data pertaining to the Medicare fee schedule for physicians' services furnished in 2006. Addendum B contains the RVUs for work, non-facility PE, facility PE, and malpractice expense, and other information for all services included in the PFS.

In previous years, we have listed many services in Addendum B that are not paid under the PFS. To avoid publishing as many pages of codes for these services, we are not including clinical laboratory codes and most alpha-numeric codes (Healthcare Common Procedure Coding System (HCPCS) codes not included in CPT) in Addendum B.

Addendum B—2006 Relative Value Units and Related Information Used in Determining Medicare Payments for 2006

This addendum contains the following information for each CPT code and alphanumeric HCPCS code, except for: alphanumeric codes beginning with B (enteral and parenteral therapy), E (durable medical equipment), K (temporary codes for nonphysicians' services or items), or L (orthotics); and codes for anesthesiology.

Please also note the following:

- An ''NA'' in the ''Non-facility PE RVUs'' column of Addendum B means that CMS has not developed a PE RVU in the non-facility setting for the service because it is typically performed in the hospital (for example, an open heart surgery is generally performed in the hospital setting and not a physician's office).
- Services that have an ''NA'' in the ''Facility PE RVUs'' column of Addendum B are typically not paid using the PFS when provided in a facility setting. These services (which include ''incident to'' services and the technical portion of diagnostic tests) are generally paid under either the outpatient hospital prospective payment system or bundled into the hospital inpatient prospective payment system payment.

1. *CPT/HCPCS code.* This is the CPT or alphanumeric HCPCS number for the service. Alphanumeric HCPCS codes are included at the end of this addendum.

2. *Modifier.* A modifier is shown if there is a technical component (modifier TC) and a professional component (PC) (modifier –26) for the service. If there is a PC and a TC for the service, Addendum B contains three entries for the code. A code for: the global values (both professional and technical); modifier –26 (PC); and, modifier TC. The global service is not designated by a modifier, and physicians must bill using the code without a modifier if the physician furnishes both the PC and the TC of the service.

Modifier –53 is shown for a discontinued procedure. There will be RVUs for the code (CPT code 45378) with this modifier.

3. *Status indicator.* This indicator shows whether the CPT/HCPCS code is in the PFS and whether it is separately payable if the service is covered.

A = Active code. These codes are separately payable under the PFS if covered. There will be RVUs for codes with this status. The presence of an ''A'' indicator does not mean that Medicare has made a national coverage determination regarding the service. Carriers remain responsible for coverage decisions in the absence of a national Medicare policy.

B = Bundled code. Payments for covered services are always bundled into payment for other services not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident (an example is a telephone call from a hospital nurse regarding care of a patient).

C = Carrier-priced code. Carriers will establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation, such as an operative report.

D = Deleted/discontinued code. These codes are deleted effective with the beginning of the CY and are always subject to a 90 day grace period.

E = Excluded from the PFS by regulation. These codes are for items and services that CMS choses to exclude from the PFS payment by regulation. No RVUs are shown, and no payment may be made under the PFS for these codes. Payment for them, when covered, continues under reasonable charge procedures.

F = Deleted/discontinued codes. (Code not subject to a 90-day grace period.) These codes are deleted effective with the beginning of the CY and are never subject to a grace period. This indicator is no longer effective with the 2006 PFS as of January 1, 2006.

G = Code not valid for Medicare purposes. Medicare does not recognize codes assigned this status. Medicare uses another code for reporting of, and payment for, these services. (Code subject to a 90 day grace period.) This indicator is no longer effective with the 2006 PFS as of January 1, 2006.

H = Deleted modifier. For 2000 and later years, either the TC or PC component shown for the code has been deleted and the deleted component is shown in the data base with the H status indicator.

I = Not valid for Medicare purposes. Medicare uses another code for the

reporting of, and the payment for these services. (Code not subject to a 90-day grace period.)

N = Noncovered service. These codes are noncovered services. Medicare payment may not be made for these codes. If RVUs are shown, they are not used for Medicare payment.

P = Bundled or excluded code. There are no RVUs for these services. No separate payment is made for them under the PFS.

—If the item or service is covered as incident to a physician's service and is furnished on the same day as a physician's service, payment for it is bundled into the payment for the physician's service to which it is incident (an example is an elastic bandage furnished by a physician incident to a physician's service).

—If the item or service is covered as other than incident to a physician's service, it is excluded from the PFS (for example, colostomy supplies) and is paid under the other payment provisions of the Act.

R = Restricted coverage. Special coverage instructions apply. If the service is covered and no RVUs are shown, it is carrier-priced.

T = There are RVUs for these services, but they are only paid if there are no other services payable under the PFS billed on the same date by the same provider. If any other services payable under the PFS are billed on the same date by the same provider, these services are bundled into the service(s) for which payment is made.

X = Exclusion by law. These codes represent an item or service that is not within the definition of ''physicians' services'' for PFS payment purposes. No RVUs are shown for these codes, and no payment may be made under the PFS. (Examples are ambulance services and clinical diagnostic laboratory services.)

4. *Description of code.* This is an abbreviated version of the narrative description of the code.

5. *Physician work RVUs.* These are the RVUs for the physician work for this service in 2006. Codes that are not used for Medicare payment are identified with a ''+.''

6. *Non-facility practice expense RVUs.* These are the resource-based PE RVUs for non-facility settings.

7. *Facility practice expense RVUs.* These are the resource-based PE RVUs for facility settings.

8. *Malpractice expense RVUs.* These are the RVUs for the malpractice expense for the service for 2006.

9. *Non-facility total.* This is the sum of the work, non-facility practice expense, and malpractice expense RVUs.

10. *Facility total.* This is the sum of the work, facility PE, and malpractice expense RVUs.

11. *Global period.* This indicator shows the number of days in the global period for the code (0, 10, or 90 days). An explanation of the alpha codes follows:

MMM = The code describes a service furnished in uncomplicated maternity cases including antepartum care, delivery, and postpartum care. The usual global surgical concept does not apply. See the 1999 Physicians' Current Procedural Terminology for specific definitions.

XXX = The global concept does not apply.

YYY = The global period is to be set by the carrier (for example, unlisted surgery codes).

ZZZ = Code related to another service that is always included in the global period of the other service. (**Note:** Physician work and PE are associated with intra service time and in some instances the post service time.)

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
0001F		I	Heart failure assessed	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0003T		C	Cervicography	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0005F		I	Osteoarthritis assessed	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0008T		C	Upper gi endoscopy w/suture	0.00	0.00	0.00	0.00	0.00	.00	XXX
0016T		C	Thermotx choroid vasc lesion	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0017T		C	Photocoagulat macular drusen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0018T		C	Transcranial magnetic stimul	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0019T		C	Extracorp shock wv tx,ms nos	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0021T		C	Fetal oximetry, trnsvag/cerv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0024T		C	Transcath cardiac reduction	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0026T		C	Measure remnant lipoproteins	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0027T		C	Endoscopic epidural lysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0028T		C	Dexa body composition study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0029T		C	Magnetic tx for incontinence	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0030T		C	Antiprothrombin antibody	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0031T		C	Speculoscopy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0032T		C	Speculoscopy w/direct sample	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0041T		C	Detect ur infect agnt w/cpas	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0042T		C	Ct perfusion w/contrast, cbf	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0043T		C	Co expired gas analysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0044T		C	Whole body photography	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0045T		C	Whole body photography	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0046T		C	Cath lavage, mammary duct(s	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0047T		C	Cath lavage, mammary duct(s)	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0048T		C	Implant ventricular device	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0049T		C	External circulation assist	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0050T		C	Removal circulation assist	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0051T		C	Implant total heart system	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0052T		C	Replace component heart syst	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0053T		C	Replace component heart syst	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0054T		C	Bone surgery using computer	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0055T		C	Bone surgery using computer	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0056T		C	Bone surgery using computer	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0058T		C	Cryopreservation, ovary tiss	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0059T		C	Cryopreservation, oocyte	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0060T		C	Electrical impedance scan	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0061T		C	Destruction of tumor, breast	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0062T		C	Rep intradisc annulus;1 lev	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0063T		C	Rep intradisc annulus;>1lev	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0064T		C	Spectroscop eval expired gas	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0065T		C	Ocular photoscreen bilat	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0066T	26	N	Ct colonography;screen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0066T	TC	N	Ct colonography;screen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0066T		N	Ct colonography;screen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0067T	26	C	Ct colonography;dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0067T	TC	C	Ct colonography;dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0067T		C	Ct colonography;dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0068T		C	Interp/rept heart sound	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0069T		C	Analysis only heart sound	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0070T		C	Interp only heart sound	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0071T		C	U/s leiomyomata ablate <200	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0072T		C	U/s leiomyomata ablate >200	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0073T		A	Delivery, comp imrt	0.00	18.07	NA	0.13	18.20	NA	XXX
0074T		N	Online physician e/m	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0075T	26	C	Perq stent/chest vert art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0075T	TC	C	Perq stent/chest vert art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0075T		C	Perq stent/chest vert art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0076T	26	C	S&i stent/chest vert art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0076T	TC	C	S&i stent/chest vert art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0076T		C	S&i stent/chest vert art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0077T		C	Cereb therm perfusion probe	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0078T		C	Endovasc aort repr w/device	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0079T		C	Endovasc visc extnsn repr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0080T		C	Endovasc aort repr rad s&i	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0081T		C	Endovasc visc extnsn s&i	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0082T		C	Stereotactic rad delivery	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0083T		C	Stereotactic rad tx mngmt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0084T		C	Temp prostate urethral stent	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0085T		C	Breath test heart reject	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0086T		C	L ventricle fill pressure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0087T		C	Sperm eval hyaluronan	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0088T		C	Rf tongue base vol reduxn	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0089T		C	Actigraphy testing, 3-day	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0090T		C	Cervical artific disc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0091T		C	Lumbar artific disc	0.00	0.00	0.00	0.00	0.00	0.00	XXX

[1] CPT codes and descriptions only are copyright 2005 American Medical Association. All Rights Reserved.
[2] Copyright 2005 American Dental Association. All rights reserved.
[3] +Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
0092T	.....	C	Artific disc addl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0093T	.....	C	Cervical artific diskectomy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0094T	.....	C	Lumbar artific diskectomy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0095T	.....	C	Artific diskectomy addl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0096T	.....	C	Rev cervical artific disc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0097T	.....	C	Rev lumbar artific disc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0098T	.....	C	Rev artific disc addl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0099T	.....	C	Implant corneal ring	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0100T	.....	C	Prosth retina receive&gen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0101T	.....	C	Extracorp shockwv tx,hi enrg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0102T	.....	C	Extracorp shockwv tx,anesth	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0103T	.....	C	Holotranscobalamin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0104T	.....	C	At rest cardio gas rebreathe	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0105T	.....	C	Exerc cardio gas rebreathe	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0106T	.....	C	Touch quant sensory test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0107T	.....	C	Vibrate quant sensory test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0108T	.....	C	Cool quant sensory test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0109T	.....	C	Heat quant sensory test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0110T	.....	C	Nos quant sensory test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0111T	.....	C	Rbc membranes fatty acids	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0115T	.....	C	Med tx mngmt 15 min	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0116T	.....	C	Med tx mngmt subsqt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0117T	.....	C	Med tx mngmt addl 15 min	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0120T	.....	C	Fibroadenoma cryoablate, ea	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0123T	.....	C	Scleral fistulization	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0124T	.....	C	Conjunctival drug placement	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0126T	.....	C	Chd risk imt study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0130T	.....	C	Chron care drug investigatn	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0133T	.....	C	Esophageal implant injexn	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0135T	.....	C	Perq cryoablate renal tumor	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0137T	.....	C	Prostate saturation sampling	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0140T	.....	C	Exhaled breath condensate ph	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0141T	.....	C	Perq islet transplant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0142T	.....	C	Open islet transplant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0143T	.....	C	Laparoscopic islet transplnt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0144T	.....	C	CT heart wo dye; qual calc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0145T	.....	C	CT heart w/wo dye funct	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0146T	.....	C	CCTA w/wo dye	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0147T	.....	C	CCTA w/wo, quan calcium	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0148T	.....	C	CCTA w/wo, strxr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0149T	.....	C	CCTA w/wo, strxr quan calc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0150T	.....	C	CCTA w/wo, disease strxr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0151T	.....	C	CT heart funct add-on	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0152T	.....	C	Computer chest add-on	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0153T	.....	C	Implant aneur sensor add-on	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0154T	.....	C	Implant aneur sensor study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0500F	.....	I	Initial prenatal care visit	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0501F	.....	I	Prenatal flow sheet	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0502F	.....	I	Subsequent prenatal care	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0503F	.....	I	Postpartum care visit	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1000F	.....	I	Tobacco use, smoking, assess	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1001F	.....	I	Tobacco use, non-smoking	0.00	0.00	0.00	0.00	0.00	0.00	XXX
10021	.....	A	Fna w/o image	1.27	2.16	0.54	0.10	3.53	1.91	XXX
10022	.....	A	Fna w/image	1.27	2.55	0.42	0.08	3.90	1.77	XXX
1002F	.....	I	Assess anginal symptom/level	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1003F	.....	I	Level of activity assess	0.00	0.00	0.00	0.00	0.00	0.00	XXX
10040	.....	A	Acne surgery	1.18	1.01	0.79	0.05	2.24	2.02	010
1004F	.....	I	Clin symp vol ovrld assess	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1005F	.....	I	Asthma symptoms evaluate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
10060	.....	A	Drainage of skin abscess	1.17	1.21	0.93	0.12	2.50	2.22	010
10061	.....	A	Drainage of skin abscess	2.40	1.83	1.50	0.26	4.49	4.16	010
1006F	.....	I	Osteoarthritis assess	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1007F	.....	I	Anti-inflm/anlgsc otc assess	0.00	0.00	0.00	0.00	0.00	0.00	XXX
10080	.....	A	Drainage of pilonidal cyst	1.17	3.11	1.11	0.11	4.39	2.39	010
10081	.....	A	Drainage of pilonidal cyst	2.45	4.08	1.50	0.24	6.77	4.19	010
1008F	.....	I	Gi/renal risk assess	0.00	0.00	0.00	0.00	0.00	0.00	XXX
10120	.....	A	Remove foreign body	1.22	2.18	0.97	0.12	3.52	2.31	010
10121	.....	A	Remove foreign body	2.69	3.52	1.79	0.33	6.54	4.81	010
10140	.....	A	Drainage of hematoma/fluid	1.53	1.78	1.29	0.19	3.50	3.01	010
10160	.....	A	Puncture drainage of lesion	1.20	1.60	1.08	0.14	2.94	2.42	010
10180	.....	A	Complex drainage, wound	2.25	2.99	1.99	0.35	5.59	4.59	010
11000	.....	A	Debride infected skin	0.60	0.58	0.22	0.07	1.25	0.89	000
11001	.....	A	Debride infected skin add-on	0.30	0.23	0.11	0.04	0.57	0.45	ZZZ
11004	.....	A	Debride genitalia & perineum	10.31	NA	3.91	0.67	NA	14.89	000
11005	.....	A	Debride abdom wall	13.75	NA	5.58	0.96	NA	20.29	000

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
11006	.....	A	Debride genit/per/abdom wall	12.61	NA	4.86	1.28	NA	18.75	000
11008	.....	A	Remove mesh from abd wall	5.00	NA	2.03	0.61	NA	7.64	ZZZ
11010	.....	A	Debride skin, fx	4.19	6.89	2.63	0.66	11.74	7.48	010
11011	.....	A	Debride skin/muscle, fx	4.94	8.18	2.35	0.74	13.86	8.03	000
11012	.....	A	Debride skin/muscle/bone, fx	6.87	12.14	3.85	1.16	20.17	11.88	000
11040	.....	A	Debride skin, partial	0.50	0.52	0.21	0.06	1.08	0.77	000
11041	.....	A	Debride skin, full	0.82	0.66	0.33	0.10	1.58	1.25	000
11042	.....	A	Debride skin/tissue	1.12	0.97	0.44	0.13	2.22	1.69	000
11043	.....	A	Debride tissue/muscle	2.38	3.39	2.60	0.32	6.09	5.30	010
11044	.....	A	Debride tissue/muscle/bone	3.06	4.46	3.76	0.43	7.95	7.25	010
11055	.....	R	Trim skin lesion	0.43	0.56	0.17	0.05	1.04	0.65	000
11056	.....	R	Trim skin lesions, 2 to 4	0.61	0.64	0.23	0.07	1.32	0.91	000
11057	.....	R	Trim skin lesions, over 4	0.79	0.74	0.30	0.10	1.63	1.19	000
11100	.....	A	Biopsy, skin lesion	0.81	1.25	0.37	0.03	2.09	1.21	000
11101	.....	A	Biopsy, skin add-on	0.41	0.33	0.19	0.02	0.76	0.62	ZZZ
11200	.....	A	Removal of skin tags	0.77	1.04	0.76	0.04	1.85	1.57	010
11201	.....	A	Remove skin tags add-on	0.29	0.16	0.12	0.02	0.47	0.43	ZZZ
11300	.....	A	Shave skin lesion	0.51	0.99	0.21	0.03	1.53	0.75	000
11301	.....	A	Shave skin lesion	0.85	1.11	0.38	0.04	2.00	1.27	000
11302	.....	A	Shave skin lesion	1.05	1.30	0.46	0.05	2.40	1.56	000
11303	.....	A	Shave skin lesion	1.24	1.58	0.52	0.07	2.89	1.83	000
11305	.....	A	Shave skin lesion	0.67	0.85	0.27	0.07	1.59	1.01	000
11306	.....	A	Shave skin lesion	0.99	1.10	0.42	0.07	2.16	1.48	000
11307	.....	A	Shave skin lesion	1.14	1.29	0.49	0.07	2.50	1.70	000
11308	.....	A	Shave skin lesion	1.41	1.45	0.59	0.13	2.99	2.13	000
11310	.....	A	Shave skin lesion	0.73	1.11	0.32	0.04	1.88	1.09	000
11311	.....	A	Shave skin lesion	1.05	1.23	0.49	0.05	2.33	1.59	000
11312	.....	A	Shave skin lesion	1.20	1.42	0.55	0.06	2.68	1.81	000
11313	.....	A	Shave skin lesion	1.62	1.81	0.72	0.10	3.53	2.44	000
11400	.....	A	Exc tr-ext b9+marg 0.5 < cm	0.85	2.00	0.88	0.06	2.91	1.79	010
11401	.....	A	Exc tr-ext b9+marg 0.6-1 cm	1.23	2.06	1.02	0.10	3.39	2.35	010
11402	.....	A	Exc tr-ext b9+marg 1.1-2 cm	1.51	2.23	1.08	0.13	3.87	2.72	010
11403	.....	A	Exc tr-ext b9+marg 2.1-3 cm	1.79	2.40	1.32	0.17	4.36	3.28	010
11404	.....	A	Exc tr-ext b9+marg 3.1-4 cm	2.06	2.71	1.40	0.21	4.98	3.67	010
11406	.....	A	Exc tr-ext b9+marg > 4.0 cm	2.76	3.07	1.65	0.32	6.15	4.73	010
11420	.....	A	Exc h-f-nk-sp b9+marg 0.5 <	0.98	1.77	0.93	0.09	2.84	2.00	010
11421	.....	A	Exc h-f-nk-sp b9+marg 0.6-1	1.42	2.07	1.11	0.13	3.62	2.66	010
11422	.....	A	Exc h-f-nk-sp b9+marg 1.1-2	1.63	2.26	1.33	0.16	4.05	3.12	010
11423	.....	A	Exc h-f-nk-sp b9+marg 2.1-3	2.01	2.59	1.45	0.20	4.80	3.66	010
11424	.....	A	Exc h-f-nk-sp b9+marg 3.1-4	2.43	2.81	1.60	0.25	5.49	4.28	010
11426	.....	A	Exc h-f-nk-sp b9+marg > 4 cm	3.77	3.49	2.11	0.44	7.70	6.32	010
11440	.....	A	Exc face-mm b9+marg 0.5 < cm	1.06	2.21	1.31	0.08	3.35	2.45	010
11441	.....	A	Exc face-mm b9+marg 0.6-1 cm	1.48	2.34	1.49	0.13	3.95	3.10	010
11442	.....	A	Exc face-mm b9+marg 1.1-2 cm	1.72	2.55	1.57	0.16	4.43	3.45	010
11443	.....	A	Exc face-mm b9+marg 2.1-3 cm	2.29	2.92	1.82	0.22	5.43	4.33	010
11444	.....	A	Exc face-mm b9+marg 3.1-4 cm	3.14	3.48	2.19	0.30	6.92	5.63	010
11446	.....	A	Exc face-mm b9+marg > 4 cm	4.48	4.05	2.78	0.43	8.96	7.69	010
11450	.....	A	Removal, sweat gland lesion	2.73	5.04	2.03	0.34	8.11	5.10	090
11451	.....	A	Removal, sweat gland lesion	3.94	6.62	2.55	0.53	11.09	7.02	090
11462	.....	A	Removal, sweat gland lesion	2.51	5.12	2.02	0.32	7.95	4.85	090
11463	.....	A	Removal, sweat gland lesion	3.94	6.84	2.69	0.54	11.32	7.17	090
11470	.....	A	Removal, sweat gland lesion	3.25	5.07	2.27	0.40	8.72	5.92	090
11471	.....	A	Removal, sweat gland lesion	4.40	6.72	2.77	0.58	11.70	7.75	090
11600	.....	A	Exc tr-ext mlg+marg 0.5 < cm	1.31	2.64	0.97	0.10	4.05	2.38	010
11601	.....	A	Exc tr-ext mlg+marg 0.6-1 cm	1.80	2.71	1.22	0.12	4.63	3.14	010
11602	.....	A	Exc tr-ext mlg+marg 1.1-2 cm	1.95	2.83	1.26	0.12	4.90	3.33	010
11603	.....	A	Exc tr-ext mlg+marg 2.1-3 cm	2.19	3.08	1.33	0.16	5.43	3.68	010
11604	.....	A	Exc tr-ext mlg+marg 3.1-4 cm	2.40	3.38	1.39	0.20	5.98	3.99	010
11606	.....	A	Exc tr-ext mlg+marg > 4 cm	3.42	4.07	1.74	0.36	7.85	5.52	010
11620	.....	A	Exc h-f-nk-sp mlg+marg 0.5 <	1.19	2.60	0.95	0.09	3.88	2.23	010
11621	.....	A	Exc h-f-nk-sp mlg+marg 0.6-1	1.76	2.71	1.24	0.12	4.59	3.12	010
11622	.....	A	Exc h-f-nk-sp mlg+marg 1.1-2	2.09	2.97	1.39	0.14	5.20	3.62	010
11623	.....	A	Exc h-f-nk-sp mlg+marg 2.1-3	2.61	3.34	1.58	0.20	6.15	4.39	010
11624	.....	A	Exc h-f-nk-sp mlg+marg 3.1-4	3.06	3.75	1.78	0.27	7.08	5.11	010
11626	.....	A	Exc h-f-nk-sp mlg+mar > 4 cm	4.29	4.64	2.40	0.45	9.38	7.14	010
11640	.....	A	Exc face-mm malig+marg 0.5 <	1.35	2.66	1.11	0.11	4.12	2.57	010
11641	.....	A	Exc face-mm malig+marg 0.6-1	2.16	3.03	1.53	0.16	5.35	3.85	010
11642	.....	A	Exc face-mm malig+marg 1.1-2	2.59	3.41	1.71	0.19	6.19	4.49	010
11643	.....	A	Exc face-mm malig+marg 2.1-3	3.10	3.81	1.97	0.26	7.17	5.33	010
11644	.....	A	Exc face-mm malig+marg 3.1-4	4.02	4.69	2.46	0.37	9.08	6.85	010
11646	.....	A	Exc face-mm mlg+marg > 4 cm	5.94	5.77	3.48	0.61	12.32	10.03	010
11719	.....	R	Trim nail(s)	0.17	0.25	0.07	0.02	0.44	0.26	000
11720	.....	A	Debride nail, 1-5	0.32	0.34	0.12	0.04	0.70	0.48	000
11721	.....	A	Debride nail, 6 or more	0.54	0.44	0.21	0.07	1.05	0.82	000
11730	.....	A	Removal of nail plate	1.13	1.03	0.43	0.14	2.30	1.70	000

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
11732	.....	A	Remove nail plate, add-on	0.57	0.44	0.22	0.07	1.08	0.86	ZZZ
11740	.....	A	Drain blood from under nail	0.37	0.55	0.35	0.04	0.96	0.76	000
11750	.....	A	Removal of nail bed	1.86	2.17	1.76	0.22	4.25	3.84	010
11752	.....	A	Remove nail bed/finger tip	2.67	3.00	3.00	0.35	6.02	6.02	010
11755	.....	A	Biopsy, nail unit	1.31	1.57	0.77	0.14	3.02	2.22	000
11760	.....	A	Repair of nail bed	1.58	2.63	1.79	0.21	4.42	3.58	010
11762	.....	A	Reconstruction of nail bed	2.89	2.89	2.35	0.36	6.14	5.60	010
11765	.....	A	Excision of nail fold, toe	0.69	1.79	0.76	0.08	2.56	1.53	010
11770	.....	A	Removal of pilonidal lesion	2.61	3.49	1.50	0.33	6.43	4.44	010
11771	.....	A	Removal of pilonidal lesion	5.73	5.66	3.32	0.74	12.13	9.79	090
11772	.....	A	Removal of pilonidal lesion	6.97	7.52	5.08	0.89	15.38	12.94	090
11900	.....	A	Injection into skin lesions	0.52	0.65	0.21	0.02	1.19	0.75	000
11901	.....	A	Added skin lesions injection	0.80	0.66	0.35	0.03	1.49	1.18	000
11920	.....	R	Correct skin color defects	1.61	3.71	1.09	0.24	5.56	2.94	000
11921	.....	R	Correct skin color defects	1.93	3.97	1.27	0.29	6.19	3.49	000
11922	.....	R	Correct skin color defects	0.49	1.14	0.25	0.07	1.70	0.81	ZZZ
11950	.....	R	Therapy for contour defects	0.84	1.14	0.39	0.06	2.04	1.29	000
11951	.....	R	Therapy for contour defects	1.19	1.49	0.51	0.11	2.79	1.81	000
11952	.....	R	Therapy for contour defects	1.69	1.86	0.68	0.16	3.71	2.53	000
11954	.....	R	Therapy for contour defects	1.85	2.45	0.90	0.25	4.55	3.00	000
11960	.....	A	Insert tissue expander(s)	9.07	NA	10.42	1.31	NA	20.80	090
11970	.....	A	Replace tissue expander	7.05	NA	6.15	1.05	NA	14.25	090
11971	.....	A	Remove tissue expander(s)	2.13	9.14	3.80	0.32	11.59	6.25	090
11975	.....	N	Insert contraceptive cap	+1.48	1.42	0.57	0.17	3.07	2.22	XXX
11976	.....	R	Removal of contraceptive cap	1.78	1.72	0.68	0.21	3.71	2.67	000
11977	.....	N	Removal/reinsert contra cap	+3.30	2.28	1.26	0.37	5.95	4.93	XXX
11980	.....	A	Implant hormone pellet(s)	1.48	1.08	0.54	0.13	2.69	2.15	000
11981	.....	A	Insert drug implant device	1.48	1.70	0.68	0.12	3.30	2.28	XXX
11982	.....	A	Remove drug implant device	1.78	1.95	0.83	0.17	3.90	2.78	XXX
11983	.....	A	Remove/insert drug implant	3.30	2.29	1.47	0.23	5.82	5.00	XXX
12001	.....	A	Repair superficial wound(s)	1.70	1.99	0.77	0.15	3.84	2.62	010
12002	.....	A	Repair superficial wound(s)	1.86	2.05	0.90	0.17	4.08	2.93	010
12004	.....	A	Repair superficial wound(s)	2.24	2.33	1.01	0.21	4.78	3.46	010
12005	.....	A	Repair superficial wound(s)	2.86	2.83	1.20	0.27	5.96	4.33	010
12006	.....	A	Repair superficial wound(s)	3.66	3.40	1.51	0.35	7.41	5.52	010
12007	.....	A	Repair superficial wound(s)	4.11	3.83	1.82	0.45	8.39	6.38	010
12011	.....	A	Repair superficial wound(s)	1.76	2.14	0.78	0.16	4.06	2.70	010
12013	.....	A	Repair superficial wound(s)	1.99	2.28	0.93	0.18	4.45	3.10	010
12014	.....	A	Repair superficial wound(s)	2.46	2.58	1.06	0.23	5.27	3.75	010
12015	.....	A	Repair superficial wound(s)	3.19	3.14	1.25	0.29	6.62	4.73	010
12016	.....	A	Repair superficial wound(s)	3.92	3.56	1.52	0.37	7.85	5.81	010
12017	.....	A	Repair superficial wound(s)	4.70	NA	1.90	0.47	NA	7.07	010
12018	.....	A	Repair superficial wound(s)	5.52	NA	2.26	0.64	NA	8.42	010
12020	.....	A	Closure of split wound	2.62	3.83	1.93	0.30	6.75	4.85	010
12021	.....	A	Closure of split wound	1.84	1.83	1.41	0.24	3.91	3.49	010
12031	.....	A	Layer closure of wound(s)	2.15	2.29	0.96	0.17	4.61	3.28	010
12032	.....	A	Layer closure of wound(s)	2.47	3.85	1.80	0.16	6.48	4.43	010
12034	.....	A	Layer closure of wound(s)	2.92	3.20	1.45	0.25	6.37	4.62	010
12035	.....	A	Layer closure of wound(s)	3.42	5.21	2.16	0.39	9.02	5.97	010
12036	.....	A	Layer closure of wound(s)	4.04	5.57	2.55	0.55	10.16	7.14	010
12037	.....	A	Layer closure of wound(s)	4.66	6.11	2.97	0.66	11.43	8.29	010
12041	.....	A	Layer closure of wound(s)	2.37	2.55	1.13	0.19	5.11	3.69	010
12042	.....	A	Layer closure of wound(s)	2.74	3.27	1.46	0.17	6.18	4.37	010
12044	.....	A	Layer closure of wound(s)	3.14	3.22	1.60	0.27	6.63	5.01	010
12045	.....	A	Layer closure of wound(s)	3.63	5.28	2.29	0.41	9.32	6.33	010
12046	.....	A	Layer closure of wound(s)	4.24	6.52	2.76	0.54	11.30	7.54	010
12047	.....	A	Layer closure of wound(s)	4.64	6.36	3.09	0.58	11.58	8.31	010
12051	.....	A	Layer closure of wound(s)	2.47	3.28	1.45	0.20	5.95	4.12	010
12052	.....	A	Layer closure of wound(s)	2.77	3.23	1.43	0.17	6.17	4.37	010
12053	.....	A	Layer closure of wound(s)	3.12	3.25	1.53	0.23	6.60	4.88	010
12054	.....	A	Layer closure of wound(s)	3.45	3.57	1.63	0.30	7.32	5.38	010
12055	.....	A	Layer closure of wound(s)	4.42	4.49	2.13	0.45	9.36	7.00	010
12056	.....	A	Layer closure of wound(s)	5.23	6.77	3.06	0.59	12.59	8.88	010
12057	.....	A	Layer closure of wound(s)	5.95	6.15	3.76	0.56	12.66	10.27	010
13100	.....	A	Repair of wound or lesion	3.12	4.06	2.31	0.26	7.44	5.69	010
13101	.....	A	Repair of wound or lesion	3.91	4.67	2.69	0.26	8.84	6.86	010
13102	.....	A	Repair wound/lesion add-on	1.24	1.17	0.57	0.13	2.54	1.94	ZZZ
13120	.....	A	Repair of wound or lesion	3.30	4.15	2.35	0.26	7.71	5.91	010
13121	.....	A	Repair of wound or lesion	4.32	4.86	2.80	0.25	9.43	7.37	010
13122	.....	A	Repair wound/lesion add-on	1.44	1.51	0.63	0.15	3.10	2.22	ZZZ
13131	.....	A	Repair of wound or lesion	3.78	4.37	2.69	0.26	8.41	6.73	010
13132	.....	A	Repair of wound or lesion	5.94	5.92	4.17	0.32	12.18	10.43	010
13133	.....	A	Repair wound/lesion add-on	2.19	1.66	1.03	0.18	4.03	3.40	ZZZ
13150	.....	A	Repair of wound or lesion	3.80	4.88	2.77	0.34	9.02	6.91	010
13151	.....	A	Repair of wound or lesion	4.44	4.81	3.15	0.31	9.56	7.90	010

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
13152	.....	A	Repair of wound or lesion	6.32	6.05	4.05	0.40	12.77	10.77	010
13153	.....	A	Repair wound/lesion add-on	2.38	1.94	1.14	0.24	4.56	3.76	ZZZ
13160	.....	A	Late closure of wound	10.46	NA	7.18	1.54	NA	19.18	090
14000	.....	A	Skin tissue rearrangement	5.88	7.87	5.48	0.59	14.34	11.95	090
14001	.....	A	Skin tissue rearrangement	8.46	9.44	7.09	0.82	18.72	16.37	090
14020	.....	A	Skin tissue rearrangement	6.58	8.63	6.55	0.64	15.85	13.77	090
14021	.....	A	Skin tissue rearrangement	10.04	10.01	8.30	0.81	20.86	19.15	090
14040	.....	A	Skin tissue rearrangement	7.86	8.83	7.22	0.62	17.31	15.70	090
14041	.....	A	Skin tissue rearrangement	11.47	10.62	8.70	0.73	22.82	20.90	090
14060	.....	A	Skin tissue rearrangement	8.49	8.81	7.45	0.68	17.98	16.62	090
14061	.....	A	Skin tissue rearrangement	12.27	11.63	9.53	0.76	24.66	22.56	090
14300	.....	A	Skin tissue rearrangement	11.74	11.16	9.20	1.16	24.06	22.10	090
14350	.....	A	Skin tissue rearrangement	9.60	NA	7.16	1.34	NA	18.10	090
15000	.....	A	Wound prep, 1st 100 sq cm	3.99	3.80	2.19	0.54	8.33	6.72	000
15001	.....	A	Wound prep, addl 100 sq cm	1.00	1.35	0.41	0.14	2.49	1.55	ZZZ
15040	.....	A	Harvest cultured skin graft	2.00	4.57	1.13	0.24	6.81	3.37	000
15050	.....	A	Skin pinch graft	4.29	6.93	5.12	0.57	11.79	9.98	090
15100	.....	A	Skin splt grft, trnk/arm/leg	9.04	12.62	7.84	1.28	22.94	18.16	090
15101	.....	A	Skin splt grft t/a/l, add-on	1.72	3.74	1.17	0.24	5.70	3.13	ZZZ
15110	.....	A	Epidrm autogrft trnk/arm/leg	9.50	10.70	7.02	1.31	21.51	17.83	090
15111	.....	A	Epidrm autogrft t/a/l add-on	1.85	1.29	0.79	0.26	3.40	2.90	ZZZ
15115	.....	A	Epidrm a-grft face/nck/hf/g	9.81	9.25	7.37	1.15	20.21	18.33	090
15116	.....	A	Epidrm a-grft f/n/hf/g addl	2.50	1.58	1.12	0.33	4.41	3.95	ZZZ
15120	.....	A	Skn splt a-grft fac/nck/hf/g	9.82	10.75	7.80	1.16	21.73	18.78	090
15121	.....	A	Skn splt a-grft f/n/hf/g add	2.67	4.51	1.85	0.36	7.54	4.88	ZZZ
15130	.....	A	Derm autograft, trnk/arm/leg	7.00	9.89	6.36	0.97	17.86	14.33	090
15131	.....	A	Derm autograft t/a/l add-on	1.50	1.07	0.64	0.21	2.78	2.35	ZZZ
15135	.....	A	Derm autograft face/nck/hf/g	10.50	9.90	8.15	1.23	21.63	19.88	090
15136	.....	A	Derm autograft, f/n/hf/g add	1.50	0.89	0.67	0.20	2.59	2.37	ZZZ
15150	.....	A	Cult epiderm grft t/arm/leg	8.25	8.48	6.46	1.14	17.87	15.85	090
15151	.....	A	Cult epiderm grft t/a/l addl	2.00	1.31	0.85	0.28	3.59	3.13	ZZZ
15152	.....	A	Cult epiderm graft t/a/l +%	2.50	1.56	1.06	0.35	4.41	3.91	ZZZ
15155	.....	A	Cult epiderm graft, f/n/hf/g	9.00	7.84	6.98	1.05	17.89	17.03	090
15156	.....	A	Cult epidrm grft f/n/hfg add	2.75	1.56	1.24	0.36	4.67	4.35	ZZZ
15157	.....	A	Cult epiderm grft f/n/hfg +%	3.00	1.78	1.35	0.39	5.17	4.74	ZZZ
15170	.....	A	Acell graft trunk/arms/legs	5.00	3.84	2.37	0.55	9.39	7.92	090
15171	.....	A	Acell graft t/arm/leg add-on	1.55	0.68	0.62	0.19	2.42	2.36	ZZZ
15175	.....	A	Acellular graft, f/n/hf/g	7.00	5.44	4.01	0.82	13.26	11.83	090
15176	.....	A	Acell graft, f/n/hf/g add-on	2.45	1.11	0.99	0.29	3.85	3.73	ZZZ
15200	.....	A	Skin full graft, trunk	8.02	9.43	6.22	0.98	18.43	15.22	090
15201	.....	A	Skin full graft trunk add-on	1.32	2.57	0.62	0.19	4.08	2.13	ZZZ
15220	.....	A	Skin full graft sclp/arm/leg	7.86	9.21	6.70	0.84	17.91	15.40	090
15221	.....	A	Skin full graft add-on	1.19	2.33	0.56	0.16	3.68	1.91	ZZZ
15240	.....	A	Skin full grft face/genit/hf	9.03	10.23	7.97	0.92	20.18	17.92	090
15241	.....	A	Skin full graft add-on	1.86	2.45	0.91	0.23	4.54	3.00	ZZZ
15260	.....	A	Skin full graft een & lips	10.04	10.24	8.60	0.69	20.97	19.33	090
15261	.....	A	Skin full graft add-on	2.23	2.70	1.40	0.21	5.14	3.84	ZZZ
15300	.....	A	Apply skinallogrft, t/arm/lg	3.99	3.21	2.24	0.49	7.69	6.72	090
15301	.....	A	Apply sknallogrft t/a/l addl	1.00	0.47	0.40	0.14	1.61	1.54	ZZZ
15320	.....	A	Apply skin allogrft f/n/hf/g	4.70	3.63	2.54	0.58	8.91	7.82	090
15321	.....	A	Aply sknallogrft f/n/hfg add	1.50	0.69	0.59	0.21	2.40	2.30	ZZZ
15330	.....	A	Aply acell alogrft t/arm/leg	3.99	3.20	2.23	0.49	7.68	6.71	090
15331	.....	A	Aply acell grft t/a/l add-on	1.00	0.46	0.40	0.14	1.60	1.54	ZZZ
15335	.....	A	Apply acell graft, f/n/hf/g	4.50	3.48	2.45	0.55	8.53	7.50	090
15336	.....	A	Aply acell grft f/n/hf/g add	1.43	0.69	0.57	0.20	2.32	2.20	ZZZ
15340	.....	A	Apply cult skin substitute	3.72	4.01	2.76	0.41	8.14	6.89	010
15341	.....	A	Apply cult skin sub add-on	0.50	0.61	0.20	0.06	1.17	0.76	ZZZ
15360	.....	A	Apply cult derm sub, t/a/l	3.87	4.48	3.09	0.43	8.78	7.39	090
15361	.....	A	Aply cult derm sub t/a/l add	1.15	0.58	0.46	0.14	1.87	1.75	ZZZ
15365	.....	A	Apply cult derm sub f/n/hf/g	4.15	4.56	3.20	0.46	9.17	7.81	090
15366	.....	A	Apply cult derm f/hf/g add	1.45	0.70	0.58	0.17	2.32	2.20	ZZZ
15400	.....	A	Apply skin xenograft, t/a/l	3.99	4.02	4.02	0.47	8.48	8.48	090
15401	.....	A	Apply skn xenogrft t/a/l add	1.00	1.90	0.44	0.14	3.04	1.58	ZZZ
15420	.....	A	Apply skin xgraft, f/n/hf/g	4.50	4.79	3.80	0.52	9.81	8.82	090
15421	.....	A	Apply skn xgrft f/n/hf/g add	1.50	1.32	0.62	0.21	3.03	2.33	ZZZ
15430	.....	A	Apply acellular xenograft	5.75	6.92	6.63	0.66	13.33	13.04	090
15431	.....	C	Apply acellular xgraft add	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
15570	.....	A	Form skin pedicle flap	9.20	11.33	6.78	1.34	21.87	17.32	090
15572	.....	A	Form skin pedicle flap	9.26	9.52	6.47	1.20	19.98	16.93	090
15574	.....	A	Form skin pedicle flap	9.87	10.71	7.81	1.20	21.78	18.88	090
15576	.....	A	Form skin pedicle flap	8.68	9.78	6.90	0.87	19.33	16.45	090
15600	.....	A	Skin graft	1.91	7.62	3.07	0.27	9.80	5.25	090
15610	.....	A	Skin graft	2.42	4.70	3.43	0.35	7.47	6.20	090
15620	.....	A	Skin graft	2.94	7.80	3.89	0.35	11.09	7.18	090
15630	.....	A	Skin graft	3.27	7.06	4.16	0.34	10.67	7.77	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
15650	.....	A	Transfer skin pedicle flap	3.96	7.16	4.22	0.42	11.54	8.60	090
15732	.....	A	Muscle-skin graft, head/neck	17.81	18.09	12.25	1.99	37.89	32.05	090
15734	.....	A	Muscle-skin graft, trunk	17.76	18.16	12.41	2.61	38.53	32.78	090
15736	.....	A	Muscle-skin graft, arm	16.25	18.28	11.25	2.45	36.98	29.95	090
15738	.....	A	Muscle-skin graft, leg	17.89	18.02	11.75	2.65	38.56	32.29	090
15740	.....	A	Island pedicle flap graft	10.23	10.16	8.28	0.63	21.02	19.14	090
15750	.....	A	Neurovascular pedicle graft	11.39	NA	9.07	1.42	NA	21.88	090
15756	.....	A	Free myo/skin flap microvasc	35.18	NA	20.62	4.61	NA	60.41	090
15757	.....	A	Free skin flap, microvasc	35.18	NA	21.65	3.89	NA	60.72	090
15758	.....	A	Free fascial flap, microvasc	35.05	NA	21.63	4.23	NA	60.91	090
15760	.....	A	Composite skin graft	8.73	10.05	7.28	0.85	19.63	16.86	090
15770	.....	A	Derma-fat-fascia graft	7.51	NA	6.70	1.05	NA	15.26	090
15775	.....	R	Hair transplant punch grafts	3.95	4.24	1.30	0.52	8.71	5.77	000
15776	.....	R	Hair transplant punch grafts	5.53	5.37	2.81	0.72	11.62	9.06	000
15780	.....	A	Abrasion treatment of skin	7.28	11.55	8.27	0.67	19.50	16.22	090
15781	.....	A	Abrasion treatment of skin	4.84	6.93	5.38	0.34	12.11	10.56	090
15782	.....	A	Abrasion treatment of skin	4.31	9.88	6.57	0.34	14.53	11.22	090
15783	.....	A	Abrasion treatment of skin	4.28	6.89	4.19	0.28	11.45	8.75	090
15786	.....	A	Abrasion, lesion, single	2.03	3.36	1.32	0.11	5.50	3.46	010
15787	.....	A	Abrasion, lesions, add-on	0.33	1.09	0.16	0.04	1.46	0.53	ZZZ
15788	.....	R	Chemical peel, face, epiderm	2.09	6.73	3.09	0.11	8.93	5.29	090
15789	.....	R	Chemical peel, face, dermal	4.91	8.11	4.81	0.20	13.22	9.92	090
15792	.....	R	Chemical peel, nonfacial	1.86	7.11	4.46	0.13	9.10	6.45	090
15793	.....	A	Chemical peel, nonfacial	3.73	6.30	4.39	0.19	10.22	8.31	090
15819	.....	A	Plastic surgery, neck	9.37	NA	7.20	0.97	NA	17.54	090
15820	.....	A	Revision of lower eyelid	5.14	6.99	5.58	0.40	12.53	11.12	090
15821	.....	A	Revision of lower eyelid	5.71	7.37	5.73	0.45	13.53	11.89	090
15822	.....	A	Revision of upper eyelid	4.44	5.85	4.50	0.37	10.66	9.31	090
15823	.....	A	Revision of upper eyelid	7.04	7.87	6.45	0.50	15.41	13.99	090
15824	.....	R	Removal of forehead wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15825	.....	R	Removal of neck wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15826	.....	R	Removal of brow wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15828	.....	R	Removal of face wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15829	.....	R	Removal of skin wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15831	.....	A	Excise excessive skin tissue	12.38	NA	8.18	1.75	NA	22.31	090
15832	.....	A	Excise excessive skin tissue	11.57	NA	8.36	1.66	NA	21.59	090
15833	.....	A	Excise excessive skin tissue	10.62	NA	8.23	1.49	NA	20.34	090
15834	.....	A	Excise excessive skin tissue	10.83	NA	7.71	1.61	NA	20.15	090
15835	.....	A	Excise excessive skin tissue	11.65	NA	7.56	1.60	NA	20.81	090
15836	.....	A	Excise excessive skin tissue	9.33	NA	6.80	1.34	NA	17.47	090
15837	.....	A	Excise excessive skin tissue	8.42	8.57	7.39	1.18	18.17	16.99	090
15838	.....	A	Excise excessive skin tissue	7.12	NA	6.08	0.58	NA	13.78	090
15839	.....	A	Excise excessive skin tissue	9.37	8.85	6.41	1.22	19.44	17.00	090
15840	.....	A	Graft for face nerve palsy	13.24	NA	10.00	1.32	NA	24.56	090
15841	.....	A	Graft for face nerve palsy	23.23	NA	15.03	2.54	NA	40.80	090
15842	.....	A	Flap for face nerve palsy	37.90	NA	22.98	4.93	NA	65.81	090
15845	.....	A	Skin and muscle repair, face	12.55	NA	9.33	0.81	NA	22.69	090
15850	.....	B	Removal of sutures	+0.78	1.56	0.30	0.05	2.39	1.13	XXX
15851	.....	A	Removal of sutures	0.86	1.68	0.31	0.06	2.60	1.23	000
15852	.....	A	Dressing change not for burn	0.86	1.85	0.33	0.09	2.80	1.28	000
15860	.....	A	Test for blood flow in graft	1.95	0.83	0.78	0.27	3.05	3.00	000
15876	.....	R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15877	.....	R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15878	.....	R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15879	.....	R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15920	.....	A	Removal of tail bone ulcer	7.94	NA	5.57	1.04	NA	14.55	090
15922	.....	A	Removal of tail bone ulcer	9.89	NA	7.23	1.42	NA	18.54	090
15931	.....	A	Remove sacrum pressure sore	9.23	NA	5.70	1.25	NA	16.18	090
15933	.....	A	Remove sacrum pressure sore	10.83	NA	7.87	1.52	NA	20.22	090
15934	.....	A	Remove sacrum pressure sore	12.67	NA	8.06	1.78	NA	22.51	090
15935	.....	A	Remove sacrum pressure sore	14.55	NA	10.35	2.09	NA	26.99	090
15936	.....	A	Remove sacrum pressure sore	12.36	NA	8.24	1.76	NA	22.36	090
15937	.....	A	Remove sacrum pressure sore	14.19	NA	9.85	2.06	NA	26.10	090
15940	.....	A	Remove hip pressure sore	9.33	NA	6.19	1.31	NA	16.83	090
15941	.....	A	Remove hip pressure sore	11.41	NA	9.48	1.66	NA	22.55	090
15944	.....	A	Remove hip pressure sore	11.44	NA	8.62	1.65	NA	21.71	090
15945	.....	A	Remove hip pressure sore	12.67	NA	9.67	1.84	NA	24.18	090
15946	.....	A	Remove hip pressure sore	21.54	NA	14.41	3.16	NA	39.11	090
15950	.....	A	Remove thigh pressure sore	7.53	NA	5.43	1.04	NA	14.00	090
15951	.....	A	Remove thigh pressure sore	10.70	NA	7.88	1.49	NA	20.07	090
15952	.....	A	Remove thigh pressure sore	11.37	NA	7.77	1.60	NA	20.74	090
15953	.....	A	Remove thigh pressure sore	12.61	NA	9.02	1.79	NA	23.42	090
15956	.....	A	Remove thigh pressure sore	15.50	NA	10.80	2.21	NA	28.51	090
15958	.....	A	Remove thigh pressure sore	15.46	NA	11.07	2.25	NA	28.78	090
15999	.....	C	Removal of pressure sore	0.00	0.00	0.00	0.00	0.00	0.00	YYY

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
16000	.....	A	Initial treatment of burn(s)	0.89	0.86	0.26	0.08	1.83	1.23	000
16020	.....	A	Dress/debrid p-thick burn, s	0.80	1.29	0.58	0.08	2.17	1.46	000
16025	.....	A	Dress/debrid p-thick burn, m	1.85	1.77	0.96	0.19	3.81	3.00	000
16030	.....	A	Dress/debrid p-thick burn, l	2.08	2.18	1.12	0.24	4.50	3.44	000
16035	.....	A	Incision of burn scab, initi	3.74	NA	1.58	0.46	NA	5.78	090
16036	.....	A	Escharotomy; add'l incision	1.50	NA	0.60	0.20	NA	2.30	ZZZ
17000	.....	A	Destroy benign/premlg lesion	0.60	0.97	0.54	0.03	1.60	1.17	010
17003	.....	A	Destroy lesions, 2-14	0.15	0.11	0.07	0.01	0.27	0.23	ZZZ
17004	.....	A	Destroy lesions, 15 or more	2.79	2.31	1.59	0.11	5.21	4.49	010
17106	.....	A	Destruction of skin lesions	4.58	4.61	3.34	0.35	9.54	8.27	090
17107	.....	A	Destruction of skin lesions	9.15	7.22	5.47	0.63	17.00	15.25	090
17108	.....	A	Destruction of skin lesions	13.18	9.29	7.68	0.54	23.01	21.40	090
17110	.....	A	Destruct lesion, 1-14	0.65	1.62	0.70	0.05	2.32	1.40	010
17111	.....	A	Destruct lesion, 15 or more	0.92	1.67	0.81	0.05	2.64	1.78	010
17250	.....	A	Chemical cautery, tissue	0.50	1.22	0.34	0.06	1.78	0.90	000
17260	.....	A	Destruction of skin lesions	0.91	1.28	0.67	0.04	2.23	1.62	010
17261	.....	A	Destruction of skin lesions	1.17	1.61	0.83	0.05	2.83	2.05	010
17262	.....	A	Destruction of skin lesions	1.58	1.89	1.02	0.06	3.53	2.66	010
17263	.....	A	Destruction of skin lesions	1.79	2.06	1.09	0.07	3.92	2.95	010
17264	.....	A	Destruction of skin lesions	1.94	2.23	1.12	0.08	4.25	3.14	010
17266	.....	A	Destruction of skin lesions	2.34	2.51	1.22	0.09	4.94	3.65	010
17270	.....	A	Destruction of skin lesions	1.32	1.70	0.87	0.05	3.07	2.24	010
17271	.....	A	Destruction of skin lesions	1.49	1.78	0.98	0.06	3.33	2.53	010
17272	.....	A	Destruction of skin lesions	1.77	2.00	1.11	0.07	3.84	2.95	010
17273	.....	A	Destruction of skin lesions	2.05	2.21	1.21	0.08	4.34	3.34	010
17274	.....	A	Destruction of skin lesions	2.59	2.57	1.44	0.10	5.26	4.13	010
17276	.....	A	Destruction of skin lesions	3.20	2.95	1.68	0.16	6.31	5.04	010
17280	.....	A	Destruction of skin lesions	1.17	1.61	0.81	0.05	2.83	2.03	010
17281	.....	A	Destruction of skin lesions	1.72	1.91	1.09	0.07	3.70	2.88	010
17282	.....	A	Destruction of skin lesions	2.04	2.16	1.24	0.08	4.28	3.36	010
17283	.....	A	Destruction of skin lesions	2.64	2.55	1.49	0.11	5.30	4.24	010
17284	.....	A	Destruction of skin lesions	3.21	2.93	1.76	0.13	6.27	5.10	010
17286	.....	A	Destruction of skin lesions	4.43	3.68	2.45	0.23	8.34	7.11	010
17304	.....	A	1 stage mohs, up to 5 spec	7.59	8.26	3.57	0.30	16.15	11.46	000
17305	.....	A	2 stage mohs, up to 5 spec	2.85	3.90	1.34	0.11	6.86	4.30	000
17306	.....	A	3 stage mohs, up to 5 spec	2.85	3.92	1.35	0.11	6.88	4.31	000
17307	.....	A	Mohs addl stage up to 5 spec	2.85	3.57	1.36	0.11	6.53	4.32	000
17310	.....	A	Mohs any stage > 5 spec each	0.95	1.62	0.46	0.03	2.60	1.44	ZZZ
17340	.....	A	Cryotherapy of skin	0.76	0.37	0.36	0.05	1.18	1.17	010
17360	.....	A	Skin peel therapy	1.43	1.44	0.87	0.06	2.93	2.36	010
17380	.....	R	Hair removal by electrolysis	0.00	0.00	0.00	0.00	0.00	0.00	000
17999	.....	C	Skin tissue procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
19000	.....	A	Drainage of breast lesion	0.84	1.99	0.31	0.08	2.91	1.23	000
19001	.....	A	Drain breast lesion add-on	0.42	0.25	0.14	0.04	0.71	0.60	ZZZ
19020	.....	A	Incision of breast lesion	3.56	6.35	2.68	0.45	10.36	6.69	090
19030	.....	A	Injection for breast x-ray	1.53	2.87	0.50	0.09	4.49	2.12	000
19100	.....	A	Bx breast percut w/o image	1.27	2.09	0.42	0.16	3.52	1.85	000
19101	.....	A	Biopsy of breast, open	3.18	4.51	1.92	0.39	8.08	5.49	010
19102	.....	A	Bx breast percut w/image	2.00	3.84	0.66	0.14	5.98	2.80	000
19103	.....	A	Bx breast percut w/device	3.69	11.52	1.23	0.30	15.51	5.22	000
19110	.....	A	Nipple exploration	4.29	5.81	2.87	0.57	10.67	7.73	090
19112	.....	A	Excise breast duct fistula	3.66	6.08	2.69	0.48	10.22	6.83	090
19120	.....	A	Removal of breast lesion	5.55	4.55	3.07	0.73	10.83	9.35	090
19125	.....	A	Excision, breast lesion	6.05	4.79	3.29	0.80	11.64	10.14	090
19126	.....	A	Excision, addl breast lesion	2.93	NA	1.00	0.38	NA	4.31	ZZZ
19140	.....	A	Removal of breast tissue	5.13	7.16	3.40	0.69	12.98	9.22	090
19160	.....	A	Partial mastectomy	5.98	NA	3.43	0.79	NA	10.20	090
19162	.....	A	P-mastectomy w/ln removal	13.51	NA	6.35	1.79	NA	21.65	090
19180	.....	A	Removal of breast	8.79	NA	5.03	1.18	NA	15.00	090
19182	.....	A	Removal of breast	7.72	NA	4.76	1.04	NA	13.52	090
19200	.....	A	Removal of breast	15.47	NA	7.98	1.92	NA	25.37	090
19220	.....	A	Removal of breast	15.70	NA	8.25	2.07	NA	26.02	090
19240	.....	A	Removal of breast	15.98	NA	8.22	2.12	NA	26.32	090
19260	.....	A	Removal of chest wall lesion	15.42	NA	11.18	2.13	NA	28.73	090
19271	.....	A	Revision of chest wall	18.87	NA	18.00	2.62	NA	39.49	090
19272	.....	A	Extensive chest wall surgery	21.52	NA	18.98	2.99	NA	43.49	090
19290	.....	A	Place needle wire, breast	1.27	2.86	0.42	0.07	4.20	1.76	000
19291	.....	A	Place needle wire, breast	0.63	1.21	0.21	0.04	1.88	0.88	ZZZ
19295	.....	A	Place breast clip, percut	0.00	2.70	NA	0.01	2.71	NA	ZZZ
19296	.....	A	Place po breast cath for rad	3.63	125.75	1.53	0.36	129.74	5.52	000
19297	.....	A	Place breast cath for rad	1.72	NA	0.64	0.17	NA	2.53	ZZZ
19298	.....	A	Place breast rad tube/caths	6.00	42.28	2.42	0.43	48.71	8.85	000
19316	.....	A	Suspension of breast	10.67	NA	7.53	1.64	NA	19.84	090
19318	.....	A	Reduction of large breast	15.60	NA	11.20	2.92	NA	29.72	090
19324	.....	A	Enlarge breast	5.84	NA	4.90	0.84	NA	11.58	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
19325	.....	A	Enlarge breast with implant	8.44	NA	6.54	1.33	NA	16.31	090
19328	.....	A	Removal of breast implant	5.67	NA	5.03	0.91	NA	11.61	090
19330	.....	A	Removal of implant material	7.58	NA	6.05	1.26	NA	14.89	090
19340	.....	A	Immediate breast prosthesis	6.32	NA	3.12	1.06	NA	10.50	ZZZ
19342	.....	A	Delayed breast prosthesis	11.18	NA	8.95	1.83	NA	21.96	090
19350	.....	A	Breast reconstruction	8.91	13.88	7.19	1.41	24.20	17.51	090
19355	.....	A	Correct inverted nipple(s)	7.56	10.28	4.71	0.92	18.76	13.19	090
19357	.....	A	Breast reconstruction	18.13	NA	15.66	2.93	NA	36.72	090
19361	.....	A	Breast reconstruction	19.23	NA	12.47	2.92	NA	34.62	090
19364	.....	A	Breast reconstruction	40.94	NA	23.61	6.22	NA	70.77	090
19366	.....	A	Breast reconstruction	21.25	NA	11.61	3.24	NA	36.10	090
19367	.....	A	Breast reconstruction	25.69	NA	16.74	4.03	NA	46.46	090
19368	.....	A	Breast reconstruction	32.37	NA	18.97	5.52	NA	56.86	090
19369	.....	A	Breast reconstruction	29.78	NA	18.45	4.50	NA	52.73	090
19370	.....	A	Surgery of breast capsule	8.04	NA	6.92	1.29	NA	16.25	090
19371	.....	A	Removal of breast capsule	9.34	NA	7.84	1.62	NA	18.80	090
19380	.....	A	Revise breast reconstruction	9.13	NA	7.72	1.44	NA	18.29	090
19396	.....	A	Design custom breast implant	2.17	1.08	0.99	0.30	3.55	3.46	000
19499	.....	C	Breast surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
20000	.....	A	Incision of abscess	2.12	2.70	1.74	0.25	5.07	4.11	010
20005	.....	A	Incision of deep abscess	3.41	3.50	2.26	0.46	7.37	6.13	010
2000F	.....	I	Blood pressure measure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
2001F	.....	I	Weight record	0.00	0.00	0.00	0.00	0.00	0.00	XXX
2002F	.....	I	Clin sign vol ovrld assess	0.00	0.00	0.00	0.00	0.00	0.00	XXX
2003F	.....	I	Auscultation heart perform	0.00	0.00	0.00	0.00	0.00	0.00	XXX
2004F	.....	I	Initial exam involved joints	0.00	0.00	0.00	0.00	0.00	0.00	XXX
20100	.....	A	Explore wound, neck	10.06	NA	4.47	1.21	NA	15.74	010
20101	.....	A	Explore wound, chest	3.22	5.94	1.62	0.44	9.60	5.28	010
20102	.....	A	Explore wound, abdomen	3.93	7.48	1.91	0.49	11.90	6.33	010
20103	.....	A	Explore wound, extremity	5.29	8.60	3.40	0.75	14.64	9.44	010
20150	.....	A	Excise epiphyseal bar	13.67	NA	7.05	2.03	NA	22.75	090
20200	.....	A	Muscle biopsy	1.46	3.04	0.75	0.23	4.73	2.44	000
20205	.....	A	Deep muscle biopsy	2.35	3.90	1.19	0.33	6.58	3.87	000
20206	.....	A	Needle biopsy, muscle	0.99	6.52	0.63	0.07	7.58	1.69	000
20220	.....	A	Bone biopsy, trocar/needle	1.27	4.57	0.79	0.08	5.92	2.14	000
20225	.....	A	Bone biopsy, trocar/needle	1.87	24.52	1.13	0.22	26.61	3.22	000
20240	.....	A	Bone biopsy, excisional	3.23	NA	2.56	0.44	NA	6.23	010
20245	.....	A	Bone biopsy, excisional	7.77	NA	6.59	1.31	NA	15.67	010
20250	.....	A	Open bone biopsy	5.02	NA	3.51	1.02	NA	9.55	010
20251	.....	A	Open bone biopsy	5.55	NA	4.17	1.15	NA	10.87	010
20500	.....	A	Injection of sinus tract	1.23	2.27	1.53	0.12	3.62	2.88	010
20501	.....	A	Inject sinus tract for x-ray	0.76	2.92	0.25	0.04	3.72	1.05	000
20520	.....	A	Removal of foreign body	1.85	2.92	1.77	0.21	4.98	3.83	010
20525	.....	A	Removal of foreign body	3.49	9.17	2.63	0.51	13.17	6.63	010
20526	.....	A	Ther injection, carp tunnel	0.94	0.97	0.52	0.13	2.04	1.59	000
20550	.....	A	Inj tendon sheath/ligament	0.75	0.71	0.23	0.09	1.55	1.07	000
20551	.....	A	Inj tendon origin/insertion	0.75	0.68	0.33	0.08	1.51	1.16	000
20552	.....	A	Inj trigger point, 1/2 muscl	0.66	0.72	0.20	0.05	1.43	0.91	000
20553	.....	A	Inject trigger points, =/> 3	0.75	0.82	0.22	0.04	1.61	1.01	000
20600	.....	A	Drain/inject, joint/bursa	0.66	0.65	0.35	0.08	1.39	1.09	000
20605	.....	A	Drain/inject, joint/bursa	0.68	0.76	0.36	0.08	1.52	1.12	000
20610	.....	A	Drain/inject, joint/bursa	0.79	0.95	0.42	0.11	1.85	1.32	000
20612	.....	A	Aspirate/inj ganglion cyst	0.70	0.71	0.36	0.10	1.51	1.16	000
20615	.....	A	Treatment of bone cyst	2.28	3.52	1.85	0.20	6.00	4.33	010
20650	.....	A	Insert and remove bone pin	2.23	2.37	1.55	0.31	4.91	4.09	010
20660	.....	A	Apply, rem fixation device	2.51	3.06	1.61	0.59	6.16	4.71	000
20661	.....	A	Application of head brace	4.88	NA	4.92	1.14	NA	10.94	090
20662	.....	A	Application of pelvis brace	6.06	NA	5.54	0.56	NA	12.16	090
20663	.....	A	Application of thigh brace	5.42	NA	4.84	0.94	NA	11.20	090
20664	.....	A	Halo brace application	8.05	NA	7.06	1.74	NA	16.85	090
20665	.....	A	Removal of fixation device	1.31	2.16	1.35	0.19	3.66	2.85	010
20670	.....	A	Removal of support implant	1.74	11.57	2.11	0.28	13.59	4.13	010
20680	.....	A	Removal of support implant	3.34	8.81	3.73	0.56	12.71	7.63	090
20690	.....	A	Apply bone fixation device	3.51	NA	2.52	0.59	NA	6.62	090
20692	.....	A	Apply bone fixation device	6.40	NA	3.78	1.05	NA	11.23	090
20693	.....	A	Adjust bone fixation device	5.85	NA	5.46	0.98	NA	12.29	090
20694	.....	A	Remove bone fixation device	4.15	7.16	4.05	0.71	12.02	8.91	090
20802	.....	A	Replantation, arm, complete	41.09	NA	21.01	3.81	NA	65.91	090
20805	.....	A	Replant forearm, complete	49.93	NA	34.41	4.84	NA	89.18	090
20808	.....	A	Replantation hand, complete	61.56	NA	42.34	6.86	NA	110.76	090
20816	.....	A	Replantation digit, complete	30.89	NA	37.90	4.52	NA	73.31	090
20822	.....	A	Replantation digit, complete	25.55	NA	34.69	4.18	NA	64.42	090
20824	.....	A	Replantation thumb, complete	30.89	NA	36.65	4.61	NA	72.15	090
20827	.....	A	Replantation thumb, complete	26.37	NA	36.58	3.66	NA	66.61	090
20838	.....	A	Replantation foot, complete	41.35	NA	22.34	1.12	NA	64.81	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
20900	.....	A	Removal of bone for graft	5.57	8.45	5.69	0.94	14.96	12.20	090
20902	.....	A	Removal of bone for graft	7.54	NA	6.90	1.30	NA	15.74	090
20910	.....	A	Remove cartilage for graft	5.33	NA	5.20	0.71	NA	11.24	090
20912	.....	A	Remove cartilage for graft	6.34	NA	5.81	0.69	NA	12.84	090
20920	.....	A	Removal of fascia for graft	5.30	NA	4.23	0.66	NA	10.19	090
20922	.....	A	Removal of fascia for graft	6.60	7.56	4.88	0.70	14.86	12.18	090
20924	.....	A	Removal of tendon for graft	6.47	NA	5.90	1.04	NA	13.41	090
20926	.....	A	Removal of tissue for graft	5.52	NA	4.76	0.87	NA	11.15	090
20930	.....	B	Spinal bone allograft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
20931	.....	A	Spinal bone allograft	1.81	NA	0.93	0.43	NA	3.17	ZZZ
20936	.....	B	Spinal bone autograft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
20937	.....	A	Spinal bone autograft	2.79	NA	1.45	0.54	NA	4.78	ZZZ
20938	.....	A	Spinal bone autograft	3.02	NA	1.56	0.64	NA	5.22	ZZZ
20950	.....	A	Fluid pressure, muscle	1.26	6.86	0.99	0.20	8.32	2.45	000
20955	.....	A	Fibula bone graft, microvasc	39.15	NA	24.34	4.89	NA	68.38	090
20956	.....	A	Iliac bone graft, microvasc	39.21	NA	24.81	7.01	NA	71.03	090
20957	.....	A	Mt bone graft, microvasc	40.59	NA	18.99	7.05	NA	66.63	090
20962	.....	A	Other bone graft, microvasc	39.21	NA	26.60	6.55	NA	72.36	090
20969	.....	A	Bone/skin graft, microvasc	43.85	NA	26.71	4.79	NA	75.35	090
20970	.....	A	Bone/skin graft, iliac crest	43.00	NA	25.45	6.60	NA	75.05	090
20972	.....	A	Bone/skin graft, metatarsal	42.93	NA	20.64	5.30	NA	68.87	090
20973	.....	A	Bone/skin graft, great toe	45.69	NA	25.23	5.54	NA	76.46	090
20974	.....	A	Electrical bone stimulation	0.62	0.69	0.54	0.11	1.42	1.27	000
20975	.....	A	Electrical bone stimulation	2.60	NA	1.71	0.51	NA	4.82	000
20979	.....	A	Us bone stimulation	0.62	0.80	0.34	0.09	1.51	1.05	000
20982	.....	A	Ablate, bone tumor(s) perq	7.27	109.86	2.98	0.69	117.82	10.94	000
20999	.....	C	Musculoskeletal surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21010	.....	A	Incision of jaw joint	10.12	NA	7.11	1.11	NA	18.34	090
21015	.....	A	Resection of facial tumor	5.28	NA	5.02	0.70	NA	11.00	090
21025	.....	A	Excision of bone, lower jaw	10.04	12.28	9.38	1.32	23.64	20.74	090
21026	.....	A	Excision of facial bone(s)	4.84	7.88	6.34	0.60	13.32	11.78	090
21029	.....	A	Contour of face bone lesion	7.70	9.40	7.03	0.94	18.04	15.67	090
21030	.....	A	Excise max/zygoma b9 tumor	4.49	6.35	5.04	0.54	11.38	10.07	090
21031	.....	A	Remove exostosis, mandible	3.24	5.18	3.63	0.48	8.90	7.35	090
21032	.....	A	Remove exostosis, maxilla	3.24	5.36	3.52	0.47	9.07	7.23	090
21034	.....	A	Excise max/zygoma mlg tumor	16.15	15.97	12.70	1.71	33.83	30.56	090
21040	.....	A	Excise mandible lesion	4.49	6.41	4.73	0.54	11.44	9.76	090
21044	.....	A	Removal of jaw bone lesion	11.84	NA	9.40	1.12	NA	22.36	090
21045	.....	A	Extensive jaw surgery	16.15	NA	12.39	1.52	NA	30.06	090
21046	.....	A	Remove mandible cyst complex	12.98	NA	11.93	1.85	NA	26.76	090
21047	.....	A	Excise lwr jaw cyst w/repair	18.72	NA	13.48	2.12	NA	34.32	090
21048	.....	A	Remove maxilla cyst complex	13.48	NA	12.17	1.76	NA	27.41	090
21049	.....	A	Excis uppr jaw cyst w/repair	17.97	NA	13.06	1.59	NA	32.62	090
21050	.....	A	Removal of jaw joint	10.75	NA	9.47	1.47	NA	21.69	090
21060	.....	A	Remove jaw joint cartilage	10.21	NA	8.63	1.38	NA	20.22	090
21070	.....	A	Remove coronoid process	8.19	NA	7.12	1.27	NA	16.58	090
21076	.....	A	Prepare face/oral prosthesis	13.40	12.39	10.03	1.99	27.78	25.42	010
21077	.....	A	Prepare face/oral prosthesis	33.70	31.42	26.08	4.55	69.67	64.33	090
21079	.....	A	Prepare face/oral prosthesis	22.31	21.56	17.20	3.15	47.02	42.66	090
21080	.....	A	Prepare face/oral prosthesis	25.06	24.56	19.42	3.74	53.36	48.22	090
21081	.....	A	Prepare face/oral prosthesis	22.85	22.36	17.54	3.20	48.41	43.59	090
21082	.....	A	Prepare face/oral prosthesis	20.84	19.40	15.78	3.11	43.35	39.73	090
21083	.....	A	Prepare face/oral prosthesis	19.27	18.84	14.47	2.88	40.99	36.62	090
21084	.....	A	Prepare face/oral prosthesis	22.48	22.50	17.75	2.18	47.16	42.41	090
21085	.....	A	Prepare face/oral prosthesis	8.99	8.31	6.80	1.27	18.57	17.06	010
21086	.....	A	Prepare face/oral prosthesis	24.88	23.81	19.49	3.71	52.40	48.08	090
21087	.....	A	Prepare face/oral prosthesis	24.88	23.35	19.25	3.44	51.67	47.57	090
21088	.....	C	Prepare face/oral prosthesis	0.00	0.00	0.00	0.00	0.00	0.00	090
21089	.....	C	Prepare face/oral prosthesis	0.00	0.00	0.00	0.00	0.00	0.00	090
21100	.....	A	Maxillofacial fixation	4.21	11.56	4.75	0.34	16.11	9.30	090
21110	.....	A	Interdental fixation	5.20	9.59	8.38	0.72	15.51	14.30	090
21116	.....	A	Injection, jaw joint x-ray	0.81	4.34	0.33	0.06	5.21	1.20	000
21120	.....	A	Reconstruction of chin	4.92	10.61	7.51	0.60	16.13	13.03	090
21121	.....	A	Reconstruction of chin	7.63	9.76	7.84	0.90	18.29	16.37	090
21122	.....	A	Reconstruction of chin	8.51	NA	8.64	1.07	NA	18.22	090
21123	.....	A	Reconstruction of chin	11.14	NA	10.83	1.40	NA	23.37	090
21125	.....	A	Augmentation, lower jaw bone	10.60	55.38	8.34	0.79	66.77	19.73	090
21127	.....	A	Augmentation, lower jaw bone	11.10	42.92	9.48	1.52	55.54	22.10	090
21137	.....	A	Reduction of forehead	9.81	NA	7.75	1.32	NA	18.88	090
21138	.....	A	Reduction of forehead	12.17	NA	9.56	1.74	NA	23.47	090
21139	.....	A	Reduction of forehead	14.59	NA	11.09	1.18	NA	26.86	090
21141	.....	A	Reconstruct midface, lefort	18.07	NA	13.69	2.35	NA	34.11	090
21142	.....	A	Reconstruct midface, lefort	18.78	NA	12.86	2.38	NA	34.02	090
21143	.....	A	Reconstruct midface, lefort	19.55	NA	14.35	1.66	NA	35.56	090
21145	.....	A	Reconstruct midface, lefort	19.91	NA	13.94	2.84	NA	36.69	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
21146	.....	A	Reconstruct midface, lefort	20.68	NA	15.37	3.09	NA	39.14	090
21147	.....	A	Reconstruct midface, lefort	21.74	NA	15.09	1.84	NA	38.67	090
21150	.....	A	Reconstruct midface, lefort	25.20	NA	16.81	2.55	NA	44.56	090
21151	.....	A	Reconstruct midface, lefort	28.26	NA	23.02	2.30	NA	53.58	090
21154	.....	A	Reconstruct midface, lefort	30.47	NA	23.19	2.48	NA	56.14	090
21155	.....	A	Reconstruct midface, lefort	34.40	NA	23.96	6.64	NA	65.00	090
21159	.....	A	Reconstruct midface, lefort	42.32	NA	29.16	8.18	NA	79.66	090
21160	.....	A	Reconstruct midface, lefort	46.37	NA	27.55	4.13	NA	78.05	090
21172	.....	A	Reconstruct orbit/forehead	27.76	NA	13.79	3.55	NA	45.10	090
21175	.....	A	Reconstruct orbit/forehead	33.12	NA	17.84	4.83	NA	55.79	090
21179	.....	A	Reconstruct entire forehead	22.22	NA	14.17	2.80	NA	39.19	090
21180	.....	A	Reconstruct entire forehead	25.15	NA	15.42	3.48	NA	44.05	090
21181	.....	A	Contour cranial bone lesion	9.89	NA	7.48	1.32	NA	18.69	090
21182	.....	A	Reconstruct cranial bone	32.14	NA	19.17	2.80	NA	54.11	090
21183	.....	A	Reconstruct cranial bone	35.26	NA	20.89	4.47	NA	60.62	090
21184	.....	A	Reconstruct cranial bone	38.18	NA	22.00	5.70	NA	65.88	090
21188	.....	A	Reconstruction of midface	22.43	NA	18.92	1.69	NA	43.04	090
21193	.....	A	Reconst lwr jaw w/o graft	17.12	NA	12.69	2.23	NA	32.04	090
21194	.....	A	Reconst lwr jaw w/graft	19.81	NA	13.79	2.02	NA	35.62	090
21195	.....	A	Reconst lwr jaw w/o fixation	17.21	NA	14.86	1.64	NA	33.71	090
21196	.....	A	Reconst lwr jaw w/fixation	18.88	NA	15.74	2.07	NA	36.69	090
21198	.....	A	Reconstr lwr jaw segment	14.14	NA	12.74	1.44	NA	28.32	090
21199	.....	A	Reconstr lwr jaw w/advance	15.98	NA	9.14	1.39	NA	26.51	090
21206	.....	A	Reconstruct upper jaw bone	14.08	NA	12.67	1.33	NA	28.08	090
21208	.....	A	Augmentation of facial bones	10.21	22.39	9.61	1.09	33.69	20.91	090
21209	.....	A	Reduction of facial bones	6.71	10.83	8.09	0.90	18.44	15.70	090
21210	.....	A	Face bone graft	10.21	24.94	9.38	1.30	36.45	20.89	090
21215	.....	A	Lower jaw bone graft	10.75	42.00	9.39	1.53	54.28	21.67	090
21230	.....	A	Rib cartilage graft	10.75	NA	8.06	1.29	NA	20.10	090
21235	.....	A	Ear cartilage graft	6.71	9.87	6.43	0.61	17.19	13.75	090
21240	.....	A	Reconstruction of jaw joint	14.03	NA	12.08	2.24	NA	28.35	090
21242	.....	A	Reconstruction of jaw joint	12.93	NA	11.54	1.78	NA	26.25	090
21243	.....	A	Reconstruction of jaw joint	20.76	NA	17.48	3.25	NA	41.49	090
21244	.....	A	Reconstruction of lower jaw	11.84	NA	12.13	1.25	NA	25.22	090
21245	.....	A	Reconstruction of jaw	11.84	14.44	9.88	1.19	27.47	22.91	090
21246	.....	A	Reconstruction of jaw	12.45	NA	9.07	1.35	NA	22.87	090
21247	.....	A	Reconstruct lower jaw bone	22.60	NA	17.40	2.83	NA	42.83	090
21248	.....	A	Reconstruction of jaw	11.46	12.17	9.43	1.55	25.18	22.44	090
21249	.....	A	Reconstruction of jaw	17.49	16.77	12.73	2.48	36.74	32.70	090
21255	.....	A	Reconstruct lower jaw bone	16.69	NA	16.18	2.38	NA	35.25	090
21256	.....	A	Reconstruction of orbit	16.17	NA	11.85	1.50	NA	29.52	090
21260	.....	A	Revise eye sockets	16.50	NA	12.80	0.97	NA	30.27	090
21261	.....	A	Revise eye sockets	31.44	NA	24.30	3.42	NA	59.16	090
21263	.....	A	Revise eye sockets	28.38	NA	19.13	2.62	NA	50.13	090
21267	.....	A	Revise eye sockets	18.87	NA	19.83	1.70	NA	40.40	090
21268	.....	A	Revise eye sockets	24.44	NA	20.27	3.65	NA	48.36	090
21270	.....	A	Augmentation, cheek bone	10.21	11.68	7.27	0.72	22.61	18.20	090
21275	.....	A	Revision, orbitofacial bones	11.22	NA	8.18	1.29	NA	20.69	090
21280	.....	A	Revision of eyelid	6.02	NA	5.94	0.42	NA	12.38	090
21282	.....	A	Revision of eyelid	3.48	NA	4.49	0.26	NA	8.23	090
21295	.....	A	Revision of jaw muscle/bone	1.53	NA	2.54	0.16	NA	4.23	090
21296	.....	A	Revision of jaw muscle/bone	4.24	NA	4.92	0.34	NA	9.50	090
21299	.....	C	Cranio/maxillofacial surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21300	.....	A	Treatment of skull fracture	0.72	2.37	0.26	0.13	3.22	1.11	000
21310	.....	A	Treatment of nose fracture	0.58	2.29	0.15	0.05	2.92	0.78	000
21315	.....	A	Treatment of nose fracture	1.51	4.24	1.89	0.14	5.89	3.54	010
21320	.....	A	Treatment of nose fracture	1.85	3.92	1.62	0.18	5.95	3.65	010
21325	.....	A	Treatment of nose fracture	3.76	NA	8.64	0.31	NA	12.71	090
21330	.....	A	Treatment of nose fracture	5.37	NA	9.73	0.56	NA	15.66	090
21335	.....	A	Treatment of nose fracture	8.60	NA	9.65	0.74	NA	18.99	090
21336	.....	A	Treat nasal septal fracture	5.71	NA	9.64	0.55	NA	15.90	090
21337	.....	A	Treat nasal septal fracture	2.70	6.14	3.58	0.28	9.12	6.56	090
21338	.....	A	Treat nasoethmoid fracture	6.45	NA	14.06	0.82	NA	21.33	090
21339	.....	A	Treat nasoethmoid fracture	8.08	NA	13.94	0.96	NA	22.98	090
21340	.....	A	Treatment of nose fracture	10.75	NA	8.42	1.15	NA	20.32	090
21343	.....	A	Treatment of sinus fracture	12.93	NA	15.51	1.47	NA	29.91	090
21344	.....	A	Treatment of sinus fracture	19.69	NA	16.55	2.43	NA	38.67	090
21345	.....	A	Treat nose/jaw fracture	8.15	9.87	7.19	0.92	18.94	16.26	090
21346	.....	A	Treat nose/jaw fracture	10.59	NA	12.24	1.21	NA	24.04	090
21347	.....	A	Treat nose/jaw fracture	12.67	NA	16.24	1.47	NA	30.38	090
21348	.....	A	Treat nose/jaw fracture	16.66	NA	11.14	2.48	NA	30.28	090
21355	.....	A	Treat cheek bone fracture	3.76	6.25	3.49	0.34	10.35	7.59	010
21356	.....	A	Treat cheek bone fracture	4.14	7.14	4.56	0.46	11.74	9.16	010
21360	.....	A	Treat cheek bone fracture	6.45	NA	5.95	0.74	NA	13.14	090
21365	.....	A	Treat cheek bone fracture	14.93	NA	10.86	1.69	NA	27.48	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
21366	.....	A	Treat cheek bone fracture	17.74	NA	11.36	2.49	NA	31.59	090
21385	.....	A	Treat eye socket fracture	9.15	NA	8.30	0.97	NA	18.42	090
21386	.....	A	Treat eye socket fracture	9.15	NA	7.09	0.97	NA	17.21	090
21387	.....	A	Treat eye socket fracture	9.69	NA	8.98	1.08	NA	19.75	090
21390	.....	A	Treat eye socket fracture	10.11	NA	7.82	0.90	NA	18.83	090
21395	.....	A	Treat eye socket fracture	12.66	NA	9.05	1.44	NA	23.15	090
21400	.....	A	Treat eye socket fracture	1.40	2.62	1.88	0.15	4.17	3.43	090
21401	.....	A	Treat eye socket fracture	3.26	8.01	3.50	0.38	11.65	7.14	090
21406	.....	A	Treat eye socket fracture	7.00	NA	6.10	0.73	NA	13.83	090
21407	.....	A	Treat eye socket fracture	8.60	NA	6.88	0.94	NA	16.42	090
21408	.....	A	Treat eye socket fracture	12.36	NA	8.91	1.44	NA	22.71	090
21421	.....	A	Treat mouth roof fracture	5.13	9.36	8.33	0.73	15.22	14.19	090
21422	.....	A	Treat mouth roof fracture	8.31	NA	8.10	0.99	NA	17.40	090
21423	.....	A	Treat mouth roof fracture	10.38	NA	9.35	1.27	NA	21.00	090
21431	.....	A	Treat craniofacial fracture	7.04	NA	9.55	0.70	NA	17.29	090
21432	.....	A	Treat craniofacial fracture	8.60	NA	8.08	0.81	NA	17.49	090
21433	.....	A	Treat craniofacial fracture	25.31	NA	16.45	2.78	NA	44.54	090
21435	.....	A	Treat craniofacial fracture	17.22	NA	12.74	1.98	NA	31.94	090
21436	.....	A	Treat craniofacial fracture	28.00	NA	18.27	3.09	NA	49.36	090
21440	.....	A	Treat dental ridge fracture	2.70	7.12	6.18	0.38	10.20	9.26	090
21445	.....	A	Treat dental ridge fracture	5.37	9.78	8.39	0.78	15.93	14.54	090
21450	.....	A	Treat lower jaw fracture	2.97	7.40	6.89	0.33	10.70	10.19	090
21451	.....	A	Treat lower jaw fracture	4.86	9.38	8.42	0.63	14.87	13.91	090
21452	.....	A	Treat lower jaw fracture	1.98	13.06	4.62	0.27	15.31	6.87	090
21453	.....	A	Treat lower jaw fracture	5.53	10.77	10.76	0.74	17.04	17.03	090
21454	.....	A	Treat lower jaw fracture	6.45	NA	6.28	0.82	NA	13.55	090
21461	.....	A	Treat lower jaw fracture	8.08	24.53	12.70	0.98	33.59	21.76	090
21462	.....	A	Treat lower jaw fracture	9.78	27.69	12.75	1.27	38.74	23.80	090
21465	.....	A	Treat lower jaw fracture	11.89	NA	9.84	1.50	NA	23.23	090
21470	.....	A	Treat lower jaw fracture	15.32	NA	12.05	1.96	NA	29.33	090
21480	.....	A	Reset dislocated jaw	0.61	1.78	0.19	0.06	2.45	0.86	000
21485	.....	A	Reset dislocated jaw	3.98	8.24	7.68	0.51	12.73	12.17	090
21490	.....	A	Repair dislocated jaw	11.84	NA	9.72	1.96	NA	23.52	090
21495	.....	A	Treat hyoid bone fracture	5.68	NA	8.44	0.46	NA	14.58	090
21497	.....	A	Interdental wiring	3.85	8.47	7.66	0.50	12.82	12.01	090
21499	.....	C	Head surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21501	.....	A	Drain neck/chest lesion	3.80	6.44	3.83	0.43	10.67	8.06	090
21502	.....	A	Drain chest lesion	7.11	NA	5.65	0.97	NA	13.73	090
21510	.....	A	Drainage of bone lesion	5.73	NA	5.68	0.80	NA	12.21	090
21550	.....	A	Biopsy of neck/chest	2.06	3.59	1.72	0.16	5.81	3.94	010
21555	.....	A	Remove lesion, neck/chest	4.34	5.53	3.20	0.56	10.43	8.10	090
21556	.....	A	Remove lesion, neck/chest	5.56	NA	4.11	0.65	NA	10.32	090
21557	.....	A	Remove tumor, neck/chest	8.87	NA	5.37	1.08	NA	15.32	090
21600	.....	A	Partial removal of rib	6.88	NA	5.75	0.99	NA	13.62	090
21610	.....	A	Partial removal of rib	14.59	NA	8.89	3.07	NA	26.55	090
21615	.....	A	Removal of rib	9.86	NA	6.70	1.45	NA	18.01	090
21616	.....	A	Removal of rib and nerves	12.02	NA	8.04	1.86	NA	21.92	090
21620	.....	A	Partial removal of sternum	6.78	NA	5.99	0.98	NA	13.75	090
21627	.....	A	Sternal debridement	6.80	NA	6.32	1.02	NA	14.14	090
21630	.....	A	Extensive sternum surgery	17.35	NA	11.87	2.58	NA	31.80	090
21632	.....	A	Extensive sternum surgery	18.11	NA	11.14	2.65	NA	31.90	090
21685	.....	A	Hyoid myotomy & suspension	12.98	NA	10.00	1.06	NA	24.04	090
21700	.....	A	Revision of neck muscle	6.18	NA	4.45	0.32	NA	10.95	090
21705	.....	A	Revision of neck muscle/rib	9.59	NA	5.60	1.43	NA	16.62	090
21720	.....	A	Revision of neck muscle	5.67	2.47	2.47	0.91	9.05	9.05	090
21725	.....	A	Revision of neck muscle	6.98	NA	5.46	1.21	NA	13.65	090
21740	.....	A	Reconstruction of sternum	16.48	NA	8.54	2.36	NA	27.38	090
21742	.....	C	Repair stern/nuss w/o scope	0.00	0.00	0.00	0.00	0.00	0.00	090
21743	.....	C	Repair sternum/nuss w/scope	0.00	0.00	0.00	0.00	0.00	0.00	090
21750	.....	A	Repair of sternum separation	10.75	NA	6.13	1.63	NA	18.51	090
21800	.....	A	Treatment of rib fracture	0.96	NA	1.34	0.09	NA	2.39	090
21805	.....	A	Treatment of rib fracture	2.75	NA	3.21	0.38	NA	6.34	090
21810	.....	A	Treatment of rib fracture(s)	6.85	NA	4.98	0.94	NA	12.77	090
21820	.....	A	Treat sternum fracture	1.28	1.83	1.77	0.16	3.27	3.21	090
21825	.....	A	Treat sternum fracture	7.40	NA	6.41	1.11	NA	14.92	090
21899	.....	C	Neck/chest surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21920	.....	A	Biopsy soft tissue of back	2.06	3.29	1.47	0.14	5.49	3.67	010
21925	.....	A	Biopsy soft tissue of back	4.48	5.18	3.25	0.60	10.26	8.33	090
21930	.....	A	Remove lesion, back or flank	4.99	5.73	3.41	0.66	11.38	9.06	090
21935	.....	A	Remove tumor, back	17.93	NA	9.65	2.47	NA	30.05	090
22010	.....	A	I&d, p-spine, c/t/cerv-thor	11.05	NA	8.91	1.73	NA	21.69	090
22015	.....	A	I&d, p-spine, l/s/ls	10.94	NA	8.85	1.71	NA	21.50	090
22100	.....	A	Remove part of neck vertebra	9.72	NA	7.55	2.13	NA	19.40	090
22101	.....	A	Remove part, thorax vertebra	9.80	NA	7.77	1.90	NA	19.47	090
22102	.....	A	Remove part, lumbar vertebra	9.80	NA	8.13	1.87	NA	19.80	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
22103	.....	A	Remove extra spine segment	2.34	NA	1.21	0.44	NA	3.99	ZZZ
22110	.....	A	Remove part of neck vertebra	12.72	NA	9.19	2.76	NA	24.67	090
22112	.....	A	Remove part, thorax vertebra	12.79	NA	9.30	2.52	NA	24.61	090
22114	.....	A	Remove part, lumbar vertebra	12.79	NA	9.28	2.63	NA	24.70	090
22116	.....	A	Remove extra spine segment	2.32	NA	1.17	0.50	NA	3.99	ZZZ
22210	.....	A	Revision of neck spine	23.78	NA	15.45	5.44	NA	44.67	090
22212	.....	A	Revision of thorax spine	19.39	NA	13.31	3.90	NA	36.60	090
22214	.....	A	Revision of lumbar spine	19.42	NA	13.85	3.91	NA	37.18	090
22216	.....	A	Revise, extra spine segment	6.03	NA	3.14	1.29	NA	10.46	ZZZ
22220	.....	A	Revision of neck spine	21.34	NA	13.66	5.06	NA	40.06	090
22222	.....	A	Revision of thorax spine	21.49	NA	11.16	4.12	NA	36.77	090
22224	.....	A	Revision of lumbar spine	21.49	NA	14.26	4.18	NA	39.93	090
22226	.....	A	Revise, extra spine segment	6.03	NA	3.10	1.29	NA	10.42	ZZZ
22305	.....	A	Treat spine process fracture	2.05	2.32	1.93	0.39	4.76	4.37	090
22310	.....	A	Treat spine fracture	2.61	2.81	2.36	0.50	5.92	5.47	090
22315	.....	A	Treat spine fracture	8.83	9.71	7.35	1.85	20.39	18.03	090
22318	.....	A	Treat odontoid fx w/o graft	21.47	NA	13.42	5.28	NA	40.17	090
22319	.....	A	Treat odontoid fx w/graft	23.96	NA	14.75	6.03	NA	44.74	090
22325	.....	A	Treat spine fracture	18.27	NA	12.11	3.87	NA	34.25	090
22326	.....	A	Treat neck spine fracture	19.56	NA	12.74	4.42	NA	36.72	090
22327	.....	A	Treat thorax spine fracture	19.17	NA	12.40	3.98	NA	35.55	090
22328	.....	A	Treat each add spine fx	4.60	NA	2.27	0.94	NA	7.81	ZZZ
22505	.....	A	Manipulation of spine	1.87	NA	0.94	0.36	NA	3.17	010
22520	.....	A	Percut vertebroplasty thor	8.90	61.84	5.11	1.71	72.45	15.72	010
22521	.....	A	Percut vertebroplasty lumb	8.33	56.13	4.96	1.60	66.06	14.89	010
22522	.....	A	Percut vertebroplasty add'l	4.30	NA	1.68	0.82	NA	6.80	ZZZ
22523	.....	A	Percut kyphoplasty, thor	8.94	NA	5.92	1.43	NA	16.29	010
22524	.....	A	Percut kyphoplasty, lumbar	8.54	NA	5.71	1.36	NA	15.61	010
22525	.....	A	Percut kyphoplasty, add-on	4.47	NA	2.28	0.72	NA	7.47	ZZZ
22532	.....	A	Lat thorax spine fusion	23.96	NA	14.86	4.34	NA	43.16	090
22533	.....	A	Lat lumbar spine fusion	23.09	NA	13.63	3.15	NA	39.87	090
22534	.....	A	Lat thor/lumb, add'l seg	5.99	NA	3.04	1.25	NA	10.28	ZZZ
22548	.....	A	Neck spine fusion	25.78	NA	15.85	5.59	NA	47.22	090
22554	.....	A	Neck spine fusion	18.59	NA	12.38	4.45	NA	35.42	090
22556	.....	A	Thorax spine fusion	23.42	NA	14.77	4.34	NA	42.53	090
22558	.....	A	Lumbar spine fusion	22.25	NA	13.33	3.15	NA	38.73	090
22585	.....	A	Additional spinal fusion	5.52	NA	2.80	1.25	NA	9.57	ZZZ
22590	.....	A	Spine & skull spinal fusion	20.48	NA	13.36	4.78	NA	38.62	090
22595	.....	A	Neck spinal fusion	19.36	NA	12.87	4.40	NA	36.63	090
22600	.....	A	Neck spine fusion	16.12	NA	11.22	3.72	NA	31.06	090
22610	.....	A	Thorax spine fusion	16.00	NA	11.44	3.52	NA	30.96	090
22612	.....	A	Lumbar spine fusion	20.97	NA	14.24	4.46	NA	39.67	090
22614	.....	A	Spine fusion, extra segment	6.43	NA	3.36	1.38	NA	11.17	ZZZ
22630	.....	A	Lumbar spine fusion	20.81	NA	13.64	4.72	NA	39.17	090
22632	.....	A	Spine fusion, extra segment	5.22	NA	2.67	1.16	NA	9.05	ZZZ
22800	.....	A	Fusion of spine	18.22	NA	12.81	3.75	NA	34.78	090
22802	.....	A	Fusion of spine	30.83	NA	19.65	6.15	NA	56.63	090
22804	.....	A	Fusion of spine	36.22	NA	22.76	6.98	NA	65.96	090
22808	.....	A	Fusion of spine	26.23	NA	16.35	4.92	NA	47.50	090
22810	.....	A	Fusion of spine	30.22	NA	18.41	5.13	NA	53.76	090
22812	.....	A	Fusion of spine	32.65	NA	20.12	5.28	NA	58.05	090
22818	.....	A	Kyphectomy, 1-2 segments	31.78	NA	18.92	6.45	NA	57.15	090
22819	.....	A	Kyphectomy, 3 or more	36.39	NA	20.11	7.65	NA	64.15	090
22830	.....	A	Exploration of spinal fusion	10.83	NA	7.98	2.29	NA	21.10	090
22840	.....	A	Insert spine fixation device	12.52	NA	6.51	2.78	NA	21.81	ZZZ
22841	.....	B	Insert spine fixation device	0.00	0.00	0.00	0.00	0.00	0.00	XXX
22842	.....	A	Insert spine fixation device	12.56	NA	6.52	2.74	NA	21.82	ZZZ
22843	.....	A	Insert spine fixation device	13.44	NA	6.62	2.85	NA	22.91	ZZZ
22844	.....	A	Insert spine fixation device	16.42	NA	8.78	3.18	NA	28.38	ZZZ
22845	.....	A	Insert spine fixation device	11.94	NA	6.09	2.85	NA	20.88	ZZZ
22846	.....	A	Insert spine fixation device	12.40	NA	6.35	2.95	NA	21.70	ZZZ
22847	.....	A	Insert spine fixation device	13.78	NA	7.04	2.99	NA	23.81	ZZZ
22848	.....	A	Insert pelv fixation device	5.99	NA	3.19	1.15	NA	10.33	ZZZ
22849	.....	A	Reinsert spinal fixation	18.48	NA	11.76	3.89	NA	34.13	090
22850	.....	A	Remove spine fixation device	9.51	NA	7.01	2.04	NA	18.56	090
22851	.....	A	Apply spine prosth device	6.70	NA	3.37	1.49	NA	11.56	ZZZ
22852	.....	A	Remove spine fixation device	9.00	NA	6.81	1.89	NA	17.70	090
22855	.....	A	Remove spine fixation device	15.11	NA	9.69	3.51	NA	28.31	090
22899	.....	C	Spine surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
22900	.....	A	Remove abdominal wall lesion	5.79	NA	3.23	0.76	NA	9.78	090
22999	.....	C	Abdomen surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
23000	.....	A	Removal of calcium deposits	4.35	8.55	4.43	0.68	13.58	9.46	090
23020	.....	A	Release shoulder joint	8.92	NA	7.58	1.54	NA	18.04	090
23030	.....	A	Drain shoulder lesion	3.42	7.41	2.91	0.57	11.40	6.90	010
23031	.....	A	Drain shoulder bursa	2.74	7.88	2.73	0.46	11.08	5.93	010

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
23035	.....	A	Drain shoulder bone lesion	8.60	NA	8.29	1.47	NA	18.36	090
23040	.....	A	Exploratory shoulder surgery	9.19	NA	7.88	1.60	NA	18.67	090
23044	.....	A	Exploratory shoulder surgery	7.11	NA	6.45	1.24	NA	14.80	090
23065	.....	A	Biopsy shoulder tissues	2.27	2.49	1.62	0.20	4.96	4.09	010
23066	.....	A	Biopsy shoulder tissues	4.15	7.69	3.99	0.63	12.47	8.77	090
23075	.....	A	Removal of shoulder lesion	2.39	3.67	1.79	0.34	6.40	4.52	010
23076	.....	A	Removal of shoulder lesion	7.62	NA	5.57	1.13	NA	14.32	090
23077	.....	A	Remove tumor of shoulder	16.07	NA	10.24	2.33	NA	28.64	090
23100	.....	A	Biopsy of shoulder joint	6.02	NA	5.67	1.04	NA	12.73	090
23101	.....	A	Shoulder joint surgery	5.57	NA	5.35	0.96	NA	11.88	090
23105	.....	A	Remove shoulder joint lining	8.22	NA	7.14	1.42	NA	16.78	090
23106	.....	A	Incision of collarbone joint	5.95	NA	5.72	0.99	NA	12.66	090
23107	.....	A	Explore treat shoulder joint	8.61	NA	7.41	1.49	NA	17.51	090
23120	.....	A	Partial removal, collar bone	7.10	NA	6.48	1.23	NA	14.81	090
23125	.....	A	Removal of collar bone	9.38	NA	7.58	1.62	NA	18.58	090
23130	.....	A	Remove shoulder bone, part	7.54	NA	7.15	1.30	NA	15.99	090
23140	.....	A	Removal of bone lesion	6.88	NA	5.24	1.08	NA	13.20	090
23145	.....	A	Removal of bone lesion	9.08	NA	7.46	1.49	NA	18.03	090
23146	.....	A	Removal of bone lesion	7.82	NA	7.13	1.35	NA	16.30	090
23150	.....	A	Removal of humerus lesion	8.47	NA	6.94	1.32	NA	16.73	090
23155	.....	A	Removal of humerus lesion	10.33	NA	8.35	1.80	NA	20.48	090
23156	.....	A	Removal of humerus lesion	8.67	NA	7.40	1.50	NA	17.57	090
23170	.....	A	Remove collar bone lesion	6.85	NA	6.04	1.12	NA	14.01	090
23172	.....	A	Remove shoulder blade lesion	6.89	NA	6.30	1.01	NA	14.20	090
23174	.....	A	Remove humerus lesion	9.50	NA	8.38	1.65	NA	19.53	090
23180	.....	A	Remove collar bone lesion	8.52	NA	9.02	1.47	NA	19.01	090
23182	.....	A	Remove shoulder blade lesion	8.14	NA	8.57	1.37	NA	18.08	090
23184	.....	A	Remove humerus lesion	9.37	NA	9.34	1.63	NA	20.34	090
23190	.....	A	Partial removal of scapula	7.23	NA	6.19	1.17	NA	14.59	090
23195	.....	A	Removal of head of humerus	9.80	NA	7.75	1.70	NA	19.25	090
23200	.....	A	Removal of collar bone	12.06	NA	8.75	1.93	NA	22.74	090
23210	.....	A	Removal of shoulder blade	12.47	NA	9.02	2.02	NA	23.51	090
23220	.....	A	Partial removal of humerus	14.54	NA	10.85	2.48	NA	27.87	090
23221	.....	A	Partial removal of humerus	17.71	NA	11.75	3.05	NA	32.51	090
23222	.....	A	Partial removal of humerus	23.88	NA	15.83	3.94	NA	43.65	090
23330	.....	A	Remove shoulder foreign body	1.85	3.69	1.89	0.24	5.78	3.98	010
23331	.....	A	Remove shoulder foreign body	7.37	NA	6.81	1.27	NA	15.45	090
23332	.....	A	Remove shoulder foreign body	11.60	NA	9.35	2.02	NA	22.97	090
23350	.....	A	Injection for shoulder x-ray	1.00	3.47	0.33	0.06	4.53	1.39	000
23395	.....	A	Muscle transfer,shoulder/arm	16.82	NA	12.90	2.93	NA	32.65	090
23397	.....	A	Muscle transfers	16.11	NA	11.40	2.73	NA	30.24	090
23400	.....	A	Fixation of shoulder blade	13.52	NA	10.10	2.29	NA	25.91	090
23405	.....	A	Incision of tendon & muscle	8.36	NA	6.94	1.45	NA	16.75	090
23406	.....	A	Incise tendon(s) & muscle(s)	10.77	NA	8.36	1.87	NA	21.00	090
23410	.....	A	Repair rotator cuff, acute	12.43	NA	9.43	2.16	NA	24.02	090
23412	.....	A	Repair rotator cuff, chronic	13.29	NA	9.92	2.31	NA	25.52	090
23415	.....	A	Release of shoulder ligament	9.96	NA	8.01	1.73	NA	19.70	090
23420	.....	A	Repair of shoulder	13.28	NA	10.87	2.31	NA	26.46	090
23430	.....	A	Repair biceps tendon	9.97	NA	8.12	1.73	NA	19.82	090
23440	.....	A	Remove/transplant tendon	10.46	NA	8.28	1.82	NA	20.56	090
23450	.....	A	Repair shoulder capsule	13.38	NA	9.87	2.32	NA	25.57	090
23455	.....	A	Repair shoulder capsule	14.35	NA	10.47	2.49	NA	27.31	090
23460	.....	A	Repair shoulder capsule	15.35	NA	11.40	2.66	NA	29.41	090
23462	.....	A	Repair shoulder capsule	15.28	NA	10.78	2.59	NA	28.65	090
23465	.....	A	Repair shoulder capsule	15.83	NA	11.21	2.76	NA	29.80	090
23466	.....	A	Repair shoulder capsule	14.20	NA	11.40	2.46	NA	28.06	090
23470	.....	A	Reconstruct shoulder joint	17.12	NA	12.29	2.98	NA	32.39	090
23472	.....	A	Reconstruct shoulder joint	21.07	NA	14.45	3.66	NA	39.18	090
23480	.....	A	Revision of collar bone	11.16	NA	8.80	1.94	NA	21.90	090
23485	.....	A	Revision of collar bone	13.41	NA	9.92	2.33	NA	25.66	090
23490	.....	A	Reinforce clavicle	11.84	NA	8.72	1.47	NA	22.03	090
23491	.....	A	Reinforce shoulder bones	14.19	NA	10.74	2.46	NA	27.39	090
23500	.....	A	Treat clavicle fracture	2.08	2.88	2.53	0.30	5.26	4.91	090
23505	.....	A	Treat clavicle fracture	3.68	4.42	3.85	0.61	8.71	8.14	090
23515	.....	A	Treat clavicle fracture	7.40	NA	6.57	1.28	NA	15.25	090
23520	.....	A	Treat clavicle dislocation	2.16	2.86	2.75	0.34	5.36	5.25	090
23525	.....	A	Treat clavicle dislocation	3.59	4.55	3.95	0.46	8.60	8.00	090
23530	.....	A	Treat clavicle dislocation	7.30	NA	5.95	1.20	NA	14.45	090
23532	.....	A	Treat clavicle dislocation	8.00	NA	6.99	1.38	NA	16.37	090
23540	.....	A	Treat clavicle dislocation	2.23	2.87	2.37	0.29	5.39	4.89	090
23545	.....	A	Treat clavicle dislocation	3.25	4.20	3.37	0.35	7.80	6.97	090
23550	.....	A	Treat clavicle dislocation	7.23	NA	6.39	1.25	NA	14.87	090
23552	.....	A	Treat clavicle dislocation	8.44	NA	7.34	1.46	NA	17.24	090
23570	.....	A	Treat shoulder blade fx	2.23	3.02	2.90	0.36	5.61	5.49	090
23575	.....	A	Treat shoulder blade fx	4.05	4.89	4.32	0.59	9.53	8.96	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
23585	.....	A	Treat scapula fracture	8.95	NA	7.66	1.54	NA	18.15	090
23600	.....	A	Treat humerus fracture	2.93	4.56	3.56	0.48	7.97	6.97	090
23605	.....	A	Treat humerus fracture	4.86	6.17	5.12	0.84	11.87	10.82	090
23615	.....	A	Treat humerus fracture	9.34	NA	8.86	1.62	NA	19.82	090
23616	.....	A	Treat humerus fracture	21.24	NA	14.18	3.69	NA	39.11	090
23620	.....	A	Treat humerus fracture	2.40	3.62	2.99	0.40	6.42	5.79	090
23625	.....	A	Treat humerus fracture	3.92	4.95	4.29	0.67	9.54	8.88	090
23630	.....	A	Treat humerus fracture	7.34	NA	6.65	1.27	NA	15.26	090
23650	.....	A	Treat shoulder dislocation	3.38	3.78	2.77	0.30	7.46	6.45	090
23655	.....	A	Treat shoulder dislocation	4.56	NA	4.18	0.69	NA	9.43	090
23660	.....	A	Treat shoulder dislocation	7.48	NA	6.40	1.29	NA	15.17	090
23665	.....	A	Treat dislocation/fracture	4.46	5.35	4.73	0.71	10.52	9.90	090
23670	.....	A	Treat dislocation/fracture	7.89	NA	6.85	1.36	NA	16.10	090
23675	.....	A	Treat dislocation/fracture	6.04	6.85	5.85	1.01	13.90	12.90	090
23680	.....	A	Treat dislocation/fracture	10.04	NA	8.13	1.75	NA	19.92	090
23700	.....	A	Fixation of shoulder	2.52	NA	2.18	0.44	NA	5.14	010
23800	.....	A	Fusion of shoulder joint	14.14	NA	10.44	2.35	NA	26.93	090
23802	.....	A	Fusion of shoulder joint	16.58	NA	10.20	2.70	NA	29.48	090
23900	.....	A	Amputation of arm & girdle	19.69	NA	11.74	3.18	NA	34.61	090
23920	.....	A	Amputation at shoulder joint	14.59	NA	9.95	2.46	NA	27.00	090
23921	.....	A	Amputation follow-up surgery	5.48	NA	5.09	0.78	NA	11.35	090
23929	.....	C	Shoulder surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
23930	.....	A	Drainage of arm lesion	2.94	6.34	2.32	0.43	9.71	5.69	010
23931	.....	A	Drainage of arm bursa	1.79	5.93	2.18	0.28	8.00	4.25	010
23935	.....	A	Drain arm/elbow bone lesion	6.08	NA	5.93	1.05	NA	13.06	090
24000	.....	A	Exploratory elbow surgery	5.81	NA	5.43	0.97	NA	12.21	090
24006	.....	A	Release elbow joint	9.30	NA	7.77	1.50	NA	18.57	090
24065	.....	A	Biopsy arm/elbow soft tissue	2.08	3.22	1.75	0.17	5.47	4.00	010
24066	.....	A	Biopsy arm/elbow soft tissue	5.20	8.96	4.14	0.80	14.96	10.14	090
24075	.....	A	Remove arm/elbow lesion	3.91	7.37	3.41	0.56	11.84	7.88	090
24076	.....	A	Remove arm/elbow lesion	6.29	NA	4.87	0.95	NA	12.11	090
24077	.....	A	Remove tumor of arm/elbow	11.74	NA	7.76	1.72	NA	21.22	090
24100	.....	A	Biopsy elbow joint lining	4.92	NA	4.53	0.85	NA	10.30	090
24101	.....	A	Explore/treat elbow joint	6.12	NA	5.95	1.03	NA	13.10	090
24102	.....	A	Remove elbow joint lining	8.02	NA	6.88	1.33	NA	16.23	090
24105	.....	A	Removal of elbow bursa	3.60	NA	4.40	0.61	NA	8.61	090
24110	.....	A	Remove humerus lesion	7.38	NA	6.68	1.28	NA	15.34	090
24115	.....	A	Remove/graft bone lesion	9.62	NA	7.23	1.67	NA	18.52	090
24116	.....	A	Remove/graft bone lesion	11.79	NA	9.10	2.05	NA	22.94	090
24120	.....	A	Remove elbow lesion	6.64	NA	5.94	1.10	NA	13.68	090
24125	.....	A	Remove/graft bone lesion	7.88	NA	6.18	1.06	NA	15.12	090
24126	.....	A	Remove/graft bone lesion	8.30	NA	7.04	1.16	NA	16.50	090
24130	.....	A	Removal of head of radius	6.24	NA	6.04	1.04	NA	13.32	090
24134	.....	A	Removal of arm bone lesion	9.72	NA	8.88	1.64	NA	20.24	090
24136	.....	A	Remove radius bone lesion	7.98	NA	7.24	1.38	NA	16.60	090
24138	.....	A	Remove elbow bone lesion	8.04	NA	7.80	1.34	NA	17.18	090
24140	.....	A	Partial removal of arm bone	9.17	NA	9.13	1.51	NA	19.81	090
24145	.....	A	Partial removal of radius	7.57	NA	8.08	1.25	NA	16.90	090
24147	.....	A	Partial removal of elbow	7.53	NA	8.62	1.30	NA	17.45	090
24149	.....	A	Radical resection of elbow	14.18	NA	11.65	2.34	NA	28.17	090
24150	.....	A	Extensive humerus surgery	13.25	NA	10.02	2.32	NA	25.59	090
24151	.....	A	Extensive humerus surgery	15.56	NA	11.54	2.59	NA	29.69	090
24152	.....	A	Extensive radius surgery	10.04	NA	7.75	1.48	NA	19.27	090
24153	.....	A	Extensive radius surgery	11.52	NA	5.59	0.74	NA	17.85	090
24155	.....	A	Removal of elbow joint	11.71	NA	8.42	1.92	NA	22.05	090
24160	.....	A	Remove elbow joint implant	7.82	NA	6.91	1.30	NA	16.03	090
24164	.....	A	Remove radius head implant	6.22	NA	5.79	1.03	NA	13.04	090
24200	.....	A	Removal of arm foreign body	1.76	3.42	1.63	0.20	5.38	3.59	010
24201	.....	A	Removal of arm foreign body	4.55	9.84	4.24	0.72	15.11	9.51	090
24220	.....	A	Injection for elbow x-ray	1.31	3.64	0.44	0.08	5.03	1.83	000
24300	.....	A	Manipulate elbow w/anesth	3.74	NA	5.73	0.65	NA	10.12	090
24301	.....	A	Muscle/tendon transfer	10.18	NA	8.20	1.66	NA	20.04	090
24305	.....	A	Arm tendon lengthening	7.44	NA	6.73	1.15	NA	15.32	090
24310	.....	A	Revision of arm tendon	5.97	NA	5.60	0.96	NA	12.53	090
24320	.....	A	Repair of arm tendon	10.54	NA	7.55	1.73	NA	19.82	090
24330	.....	A	Revision of arm muscles	9.59	NA	7.90	1.60	NA	19.09	090
24331	.....	A	Revision of arm muscles	10.63	NA	8.70	1.77	NA	21.10	090
24332	.....	A	Tenolysis, triceps	7.44	NA	6.79	1.23	NA	15.46	090
24340	.....	A	Repair of biceps tendon	7.88	NA	7.00	1.36	NA	16.24	090
24341	.....	A	Repair arm tendon/muscle	7.89	NA	7.94	1.36	NA	17.19	090
24342	.....	A	Repair of ruptured tendon	10.60	NA	8.54	1.85	NA	20.99	090
24343	.....	A	Repr elbow lat ligmnt w/tiss	8.64	NA	8.17	1.43	NA	18.24	090
24344	.....	A	Reconstruct elbow lat ligmnt	13.98	NA	11.55	2.36	NA	27.89	090
24345	.....	A	Repr elbw med ligmnt w/tissu	8.64	NA	8.04	1.44	NA	18.12	090
24346	.....	A	Reconstruct elbow med ligmnt	13.98	NA	11.37	2.33	NA	27.68	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
24350	.....	A	Repair of tennis elbow	5.24	NA	5.60	0.87	NA	11.71	090
24351	.....	A	Repair of tennis elbow	5.90	NA	5.94	1.02	NA	12.86	090
24352	.....	A	Repair of tennis elbow	6.42	NA	6.20	1.10	NA	13.72	090
24354	.....	A	Repair of tennis elbow	6.47	NA	6.17	1.07	NA	13.71	090
24356	.....	A	Revision of tennis elbow	6.67	NA	6.33	1.11	NA	14.11	090
24360	.....	A	Reconstruct elbow joint	12.32	NA	9.50	2.05	NA	23.87	090
24361	.....	A	Reconstruct elbow joint	14.06	NA	10.61	2.18	NA	26.85	090
24362	.....	A	Reconstruct elbow joint	14.97	NA	10.07	2.60	NA	27.64	090
24363	.....	A	Replace elbow joint	18.46	NA	13.75	3.01	NA	35.22	090
24365	.....	A	Reconstruct head of radius	8.38	NA	7.22	1.41	NA	17.01	090
24366	.....	A	Reconstruct head of radius	9.12	NA	7.56	1.52	NA	18.20	090
24400	.....	A	Revision of humerus	11.04	NA	8.88	1.92	NA	21.84	090
24410	.....	A	Revision of humerus	14.80	NA	10.34	2.57	NA	27.71	090
24420	.....	A	Revision of humerus	13.42	NA	10.57	2.17	NA	26.16	090
24430	.....	A	Repair of humerus	12.79	NA	9.77	2.21	NA	24.77	090
24435	.....	A	Repair humerus with graft	13.15	NA	10.91	2.27	NA	26.33	090
24470	.....	A	Revision of elbow joint	8.73	NA	7.74	1.48	NA	17.95	090
24495	.....	A	Decompression of forearm	8.11	NA	8.77	1.18	NA	18.06	090
24498	.....	A	Reinforce humerus	11.90	NA	9.29	2.06	NA	23.25	090
24500	.....	A	Treat humerus fracture	3.21	4.86	3.69	0.50	8.57	7.40	090
24505	.....	A	Treat humerus fracture	5.16	6.62	5.41	0.89	12.67	11.46	090
24515	.....	A	Treat humerus fracture	11.63	NA	9.41	2.02	NA	23.06	090
24516	.....	A	Treat humerus fracture	11.63	NA	9.14	2.02	NA	22.79	090
24530	.....	A	Treat humerus fracture	3.49	5.22	4.05	0.57	9.28	8.11	090
24535	.....	A	Treat humerus fracture	6.86	7.86	6.64	1.18	15.90	14.68	090
24538	.....	A	Treat humerus fracture	9.42	NA	8.73	1.64	NA	19.79	090
24545	.....	A	Treat humerus fracture	10.44	NA	8.47	1.82	NA	20.73	090
24546	.....	A	Treat humerus fracture	15.67	NA	11.35	2.73	NA	29.75	090
24560	.....	A	Treat humerus fracture	2.80	4.49	3.20	0.44	7.73	6.44	090
24565	.....	A	Treat humerus fracture	5.55	6.63	5.54	0.93	13.11	12.02	090
24566	.....	A	Treat humerus fracture	7.78	NA	8.18	1.30	NA	17.26	090
24575	.....	A	Treat humerus fracture	10.64	NA	8.42	1.86	NA	20.92	090
24576	.....	A	Treat humerus fracture	2.86	4.77	3.72	0.46	8.09	7.04	090
24577	.....	A	Treat humerus fracture	5.78	6.95	5.86	0.95	13.68	12.59	090
24579	.....	A	Treat humerus fracture	11.58	NA	8.86	2.02	NA	22.46	090
24582	.....	A	Treat humerus fracture	8.54	NA	9.14	1.48	NA	19.16	090
24586	.....	A	Treat elbow fracture	15.19	NA	11.26	2.64	NA	29.09	090
24587	.....	A	Treat elbow fracture	15.14	NA	11.05	2.52	NA	28.71	090
24600	.....	A	Treat elbow dislocation	4.22	4.87	3.51	0.50	9.59	8.23	090
24605	.....	A	Treat elbow dislocation	5.41	NA	5.38	0.89	NA	11.68	090
24615	.....	A	Treat elbow dislocation	9.41	NA	7.84	1.60	NA	18.85	090
24620	.....	A	Treat elbow fracture	6.97	NA	6.27	1.07	NA	14.31	090
24635	.....	A	Treat elbow fracture	13.17	NA	14.09	2.28	NA	29.54	090
24640	.....	A	Treat elbow dislocation	1.20	1.85	0.80	0.12	3.17	2.12	010
24650	.....	A	Treat radius fracture	2.16	3.79	2.76	0.35	6.30	5.27	090
24655	.....	A	Treat radius fracture	4.39	5.97	4.80	0.70	11.06	9.89	090
24665	.....	A	Treat radius fracture	8.13	NA	7.53	1.41	NA	17.07	090
24666	.....	A	Treat radius fracture	9.48	NA	8.09	1.62	NA	19.19	090
24670	.....	A	Treat ulnar fracture	2.54	4.12	3.08	0.41	7.07	6.03	090
24675	.....	A	Treat ulnar fracture	4.71	6.02	4.98	0.81	11.54	10.50	090
24685	.....	A	Treat ulnar fracture	8.79	NA	7.54	1.52	NA	17.85	090
24800	.....	A	Fusion of elbow joint	11.18	NA	8.77	1.63	NA	21.58	090
24802	.....	A	Fusion/graft of elbow joint	13.67	NA	10.41	2.37	NA	26.45	090
24900	.....	A	Amputation of upper arm	9.59	NA	7.08	1.53	NA	18.20	090
24920	.....	A	Amputation of upper arm	9.53	NA	6.96	1.61	NA	18.10	090
24925	.....	A	Amputation follow-up surgery	7.06	NA	6.10	1.14	NA	14.30	090
24930	.....	A	Amputation follow-up surgery	10.23	NA	7.26	1.67	NA	19.16	090
24931	.....	A	Amputate upper arm & implant	12.70	NA	5.74	1.89	NA	20.33	090
24935	.....	A	Revision of amputation	15.54	NA	8.04	2.13	NA	25.71	090
24940	.....	C	Revision of upper arm	0.00	0.00	0.00	0.00	0.00	0.00	090
24999	.....	C	Upper arm/elbow surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
25000	.....	A	Incision of tendon sheath	3.37	NA	6.89	0.55	NA	10.81	090
25001	.....	A	Incise flexor carpi radialis	3.37	NA	4.24	0.55	NA	8.16	090
25020	.....	A	Decompress forearm 1 space	5.91	NA	9.59	0.93	NA	16.43	090
25023	.....	A	Decompress forearm 1 space	12.94	NA	14.98	2.03	NA	29.95	090
25024	.....	A	Decompress forearm 2 spaces	9.49	NA	7.49	1.36	NA	18.34	090
25025	.....	A	Decompress forearm 2 spaces	16.52	NA	10.00	1.82	NA	28.34	090
25028	.....	A	Drainage of forearm lesion	5.24	NA	8.18	0.81	NA	14.23	090
25031	.....	A	Drainage of forearm bursa	4.13	NA	7.94	0.63	NA	12.70	090
25035	.....	A	Treat forearm bone lesion	7.35	NA	13.63	1.24	NA	22.22	090
25040	.....	A	Explore/treat wrist joint	7.17	NA	7.32	1.15	NA	15.64	090
25065	.....	A	Biopsy forearm soft tissues	1.99	3.23	1.91	0.15	5.37	4.05	010
25066	.....	A	Biopsy forearm soft tissues	4.12	NA	7.08	0.64	NA	11.84	090
25075	.....	A	Removal forearm lesion subcu	3.73	NA	5.91	0.55	NA	10.19	090
25076	.....	A	Removal forearm lesion deep	4.91	NA	9.57	0.74	NA	15.22	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
25077	.....	A	Remove tumor, forearm/wrist	9.75	NA	12.12	1.42	NA	23.29	090
25085	.....	A	Incision of wrist capsule	5.49	NA	7.14	0.85	NA	13.48	090
25100	.....	A	Biopsy of wrist joint	3.89	NA	5.29	0.59	NA	9.77	090
25101	.....	A	Explore/treat wrist joint	4.68	NA	5.91	0.75	NA	11.34	090
25105	.....	A	Remove wrist joint lining	5.84	NA	7.32	0.92	NA	14.08	090
25107	.....	A	Remove wrist joint cartilage	6.42	NA	8.36	0.99	NA	15.77	090
25110	.....	A	Remove wrist tendon lesion	3.91	NA	7.07	0.62	NA	11.60	090
25111	.....	A	Remove wrist tendon lesion	3.38	NA	4.71	0.53	NA	8.62	090
25112	.....	A	Reremove wrist tendon lesion	4.52	NA	5.27	0.70	NA	10.49	090
25115	.....	A	Remove wrist/forearm lesion	8.81	NA	14.07	1.31	NA	24.19	090
25116	.....	A	Remove wrist/forearm lesion	7.10	NA	13.18	1.11	NA	21.39	090
25118	.....	A	Excise wrist tendon sheath	4.36	NA	5.76	0.68	NA	10.80	090
25119	.....	A	Partial removal of ulna	6.03	NA	7.62	0.96	NA	14.61	090
25120	.....	A	Removal of forearm lesion	6.09	NA	12.12	1.00	NA	19.21	090
25125	.....	A	Remove/graft forearm lesion	7.47	NA	12.88	1.06	NA	21.41	090
25126	.....	A	Remove/graft forearm lesion	7.54	NA	13.05	1.27	NA	21.86	090
25130	.....	A	Removal of wrist lesion	5.25	NA	6.44	0.80	NA	12.49	090
25135	.....	A	Remove & graft wrist lesion	6.88	NA	7.53	1.02	NA	15.43	090
25136	.....	A	Remove & graft wrist lesion	5.96	NA	6.61	1.03	NA	13.60	090
25145	.....	A	Remove forearm bone lesion	6.36	NA	12.09	1.01	NA	19.46	090
25150	.....	A	Partial removal of ulna	7.08	NA	8.23	1.14	NA	16.45	090
25151	.....	A	Partial removal of radius	7.38	NA	12.76	1.18	NA	21.32	090
25170	.....	A	Extensive forearm surgery	11.07	NA	15.19	1.77	NA	28.03	090
25210	.....	A	Removal of wrist bone	5.94	NA	6.81	0.88	NA	13.63	090
25215	.....	A	Removal of wrist bones	7.88	NA	8.78	1.19	NA	17.85	090
25230	.....	A	Partial removal of radius	5.22	NA	6.16	0.79	NA	12.17	090
25240	.....	A	Partial removal of ulna	5.16	NA	6.97	0.81	NA	12.94	090
25246	.....	A	Injection for wrist x-ray	1.45	3.45	0.48	0.09	4.99	2.02	000
25248	.....	A	Remove forearm foreign body	5.13	NA	8.54	0.72	NA	14.39	090
25250	.....	A	Removal of wrist prosthesis	6.59	NA	6.12	1.01	NA	13.72	090
25251	.....	A	Removal of wrist prosthesis	9.56	NA	7.94	1.26	NA	18.76	090
25259	.....	A	Manipulate wrist w/anesthes	3.74	NA	5.74	0.62	NA	10.10	090
25260	.....	A	Repair forearm tendon/muscle	7.79	NA	13.35	1.19	NA	22.33	090
25263	.....	A	Repair forearm tendon/muscle	7.81	NA	13.30	1.18	NA	22.29	090
25265	.....	A	Repair forearm tendon/muscle	9.87	NA	14.35	1.47	NA	25.69	090
25270	.....	A	Repair forearm tendon/muscle	5.99	NA	12.06	0.95	NA	19.00	090
25272	.....	A	Repair forearm tendon/muscle	7.03	NA	12.83	1.11	NA	20.97	090
25274	.....	A	Repair forearm tendon/muscle	8.74	NA	13.66	1.36	NA	23.76	090
25275	.....	A	Repair forearm tendon sheath	8.49	NA	7.60	1.31	NA	17.40	090
25280	.....	A	Revise wrist/forearm tendon	7.21	NA	12.67	1.08	NA	20.96	090
25290	.....	A	Incise wrist/forearm tendon	5.28	NA	15.03	0.82	NA	21.13	090
25295	.....	A	Release wrist/forearm tendon	6.54	NA	12.19	1.00	NA	19.73	090
25300	.....	A	Fusion of tendons at wrist	8.79	NA	8.47	1.26	NA	18.52	090
25301	.....	A	Fusion of tendons at wrist	8.39	NA	8.08	1.29	NA	17.76	090
25310	.....	A	Transplant forearm tendon	8.13	NA	13.07	1.21	NA	22.41	090
25312	.....	A	Transplant forearm tendon	9.56	NA	13.98	1.41	NA	24.95	090
25315	.....	A	Revise palsy hand tendon(s)	10.18	NA	14.44	1.58	NA	26.20	090
25316	.....	A	Revise palsy hand tendon(s)	12.31	NA	16.27	1.74	NA	30.32	090
25320	.....	A	Repair/revise wrist joint	10.75	NA	11.42	1.61	NA	23.78	090
25332	.....	A	Revise wrist joint	11.39	NA	9.20	1.83	NA	22.42	090
25335	.....	A	Realignment of hand	12.86	NA	11.62	1.92	NA	26.40	090
25337	.....	A	Reconstruct ulna/radioulnar	10.15	NA	11.11	1.61	NA	22.87	090
25350	.....	A	Revision of radius	8.77	NA	14.01	1.46	NA	24.24	090
25355	.....	A	Revision of radius	10.15	NA	14.65	1.73	NA	26.53	090
25360	.....	A	Revision of ulna	8.42	NA	13.91	1.41	NA	23.74	090
25365	.....	A	Revise radius & ulna	12.38	NA	15.69	2.15	NA	30.22	090
25370	.....	A	Revise radius or ulna	13.34	NA	16.12	2.28	NA	31.74	090
25375	.....	A	Revise radius & ulna	13.02	NA	16.47	2.26	NA	31.75	090
25390	.....	A	Shorten radius or ulna	10.38	NA	14.62	1.65	NA	26.65	090
25391	.....	A	Lengthen radius or ulna	13.63	NA	16.60	2.21	NA	32.44	090
25392	.....	A	Shorten radius & ulna	13.93	NA	16.01	2.10	NA	32.04	090
25393	.....	A	Lengthen radius & ulna	15.85	NA	17.63	2.76	NA	36.24	090
25394	.....	A	Repair carpal bone, shorten	10.38	NA	8.08	1.59	NA	20.05	090
25400	.....	A	Repair radius or ulna	10.90	NA	15.23	1.82	NA	27.95	090
25405	.....	A	Repair/graft radius or ulna	14.36	NA	17.32	2.32	NA	34.00	090
25415	.....	A	Repair radius & ulna	13.33	NA	16.56	2.17	NA	32.06	090
25420	.....	A	Repair/graft radius & ulna	16.31	NA	18.32	2.61	NA	37.24	090
25425	.....	A	Repair/graft radius or ulna	13.19	NA	21.45	2.08	NA	36.72	090
25426	.....	A	Repair/graft radius & ulna	15.80	NA	16.60	2.54	NA	34.94	090
25430	.....	A	Vasc graft into carpal bone	9.24	NA	7.36	1.27	NA	17.87	090
25431	.....	A	Repair nonunion carpal bone	10.42	NA	8.42	1.90	NA	20.74	090
25440	.....	A	Repair/graft wrist bone	10.42	NA	9.43	1.63	NA	21.48	090
25441	.....	A	Reconstruct wrist joint	12.88	NA	10.03	2.07	NA	24.98	090
25442	.....	A	Reconstruct wrist joint	10.83	NA	8.91	1.53	NA	21.27	090
25443	.....	A	Reconstruct wrist joint	10.37	NA	8.80	1.37	NA	20.54	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
25444	.....	A	Reconstruct wrist joint	11.13	NA	9.06	1.71	NA	21.90	090
25445	.....	A	Reconstruct wrist joint	9.68	NA	8.01	1.55	NA	19.24	090
25446	.....	A	Wrist replacement	16.53	NA	11.95	2.47	NA	30.95	090
25447	.....	A	Repair wrist joint(s)	10.35	NA	8.68	1.61	NA	20.64	090
25449	.....	A	Remove wrist joint implant	14.47	NA	10.70	2.21	NA	27.38	090
25450	.....	A	Revision of wrist joint	7.86	NA	10.22	1.36	NA	19.44	090
25455	.....	A	Revision of wrist joint	9.48	NA	10.89	0.96	NA	21.33	090
25490	.....	A	Reinforce radius	9.53	NA	13.77	1.43	NA	24.73	090
25491	.....	A	Reinforce ulna	9.95	NA	14.50	1.60	NA	26.05	090
25492	.....	A	Reinforce radius and ulna	12.31	NA	15.34	2.14	NA	29.79	090
25500	.....	A	Treat fracture of radius	2.45	3.58	2.72	0.35	6.38	5.52	090
25505	.....	A	Treat fracture of radius	5.20	6.56	5.44	0.90	12.66	11.54	090
25515	.....	A	Treat fracture of radius	9.17	NA	7.48	1.59	NA	18.24	090
25520	.....	A	Treat fracture of radius	6.25	6.88	6.08	1.08	14.21	13.41	090
25525	.....	A	Treat fracture of radius	12.22	NA	10.02	2.12	NA	24.36	090
25526	.....	A	Treat fracture of radius	12.96	NA	13.54	2.19	NA	28.69	090
25530	.....	A	Treat fracture of ulna	2.09	3.77	2.87	0.34	6.20	5.30	090
25535	.....	A	Treat fracture of ulna	5.13	6.03	5.31	0.89	12.05	11.33	090
25545	.....	A	Treat fracture of ulna	8.89	NA	7.68	1.53	NA	18.10	090
25560	.....	A	Treat fracture radius & ulna	2.44	3.70	2.61	0.35	6.49	5.40	090
25565	.....	A	Treat fracture radius & ulna	5.62	6.72	5.44	0.93	13.27	11.99	090
25574	.....	A	Treat fracture radius & ulna	7.00	NA	7.22	1.21	NA	15.43	090
25575	.....	A	Treat fracture radius/ulna	10.43	NA	9.54	1.81	NA	21.78	090
25600	.....	A	Treat fracture radius/ulna	2.63	4.10	2.98	0.42	7.15	6.03	090
25605	.....	A	Treat fracture radius/ulna	5.80	7.25	6.24	1.00	14.05	13.04	090
25611	.....	A	Treat fracture radius/ulna	7.76	NA	8.99	1.34	NA	18.09	090
25620	.....	A	Treat fracture radius/ulna	8.54	NA	7.28	1.42	NA	17.24	090
25622	.....	A	Treat wrist bone fracture	2.61	4.28	3.11	0.41	7.30	6.13	090
25624	.....	A	Treat wrist bone fracture	4.52	6.32	5.08	0.76	11.60	10.36	090
25628	.....	A	Treat wrist bone fracture	8.42	NA	7.84	1.37	NA	17.63	090
25630	.....	A	Treat wrist bone fracture	2.88	4.19	2.95	0.45	7.52	6.28	090
25635	.....	A	Treat wrist bone fracture	4.38	5.96	3.91	0.74	11.08	9.03	090
25645	.....	A	Treat wrist bone fracture	7.24	NA	6.65	1.20	NA	15.09	090
25650	.....	A	Treat wrist bone fracture	3.05	4.32	3.18	0.45	7.82	6.68	090
25651	.....	A	Pin ulnar styloid fracture	5.35	NA	5.50	0.86	NA	11.71	090
25652	.....	A	Treat fracture ulnar styloid	7.59	NA	7.02	1.21	NA	15.82	090
25660	.....	A	Treat wrist dislocation	4.75	NA	4.72	0.58	NA	10.05	090
25670	.....	A	Treat wrist dislocation	7.91	NA	7.01	1.28	NA	16.20	090
25671	.....	A	Pin radioulnar dislocation	5.99	NA	6.17	1.00	NA	13.16	090
25675	.....	A	Treat wrist dislocation	4.66	5.67	4.66	0.62	10.95	9.94	090
25676	.....	A	Treat wrist dislocation	8.03	NA	7.32	1.34	NA	16.69	090
25680	.....	A	Treat wrist fracture	5.98	NA	4.75	0.78	NA	11.51	090
25685	.....	A	Treat wrist fracture	9.77	NA	7.82	1.60	NA	19.19	090
25690	.....	A	Treat wrist dislocation	5.49	NA	5.52	0.88	NA	11.89	090
25695	.....	A	Treat wrist dislocation	8.33	NA	7.11	1.32	NA	16.76	090
25800	.....	A	Fusion of wrist joint	9.75	NA	9.12	1.57	NA	20.44	090
25805	.....	A	Fusion/graft of wrist joint	11.26	NA	10.28	1.80	NA	23.34	090
25810	.....	A	Fusion/graft of wrist joint	10.55	NA	9.93	1.67	NA	22.15	090
25820	.....	A	Fusion of hand bones	7.44	NA	7.87	1.22	NA	16.53	090
25825	.....	A	Fuse hand bones with graft	9.26	NA	9.26	1.41	NA	19.93	090
25830	.....	A	Fusion, radioulnar jnt/ulna	10.04	NA	14.45	1.55	NA	26.04	090
25900	.....	A	Amputation of forearm	9.00	NA	12.60	1.30	NA	22.90	090
25905	.....	A	Amputation of forearm	9.11	NA	12.33	1.40	NA	22.84	090
25907	.....	A	Amputation follow-up surgery	7.79	NA	11.79	1.10	NA	20.68	090
25909	.....	A	Amputation follow-up surgery	8.95	NA	12.31	1.44	NA	22.70	090
25915	.....	A	Amputation of forearm	17.05	NA	18.93	2.93	NA	38.91	090
25920	.....	A	Amputate hand at wrist	8.67	NA	7.87	1.35	NA	17.89	090
25922	.....	A	Amputate hand at wrist	7.41	NA	7.07	1.12	NA	15.60	090
25924	.....	A	Amputation follow-up surgery	8.45	NA	8.11	1.32	NA	17.88	090
25927	.....	A	Amputation of hand	8.79	NA	11.71	1.27	NA	21.77	090
25929	.....	A	Amputation follow-up surgery	7.58	NA	5.89	1.14	NA	14.61	090
25931	.....	A	Amputation follow-up surgery	7.80	NA	11.49	1.15	NA	20.44	090
25999	.....	C	Forearm or wrist surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
26010	.....	A	Drainage of finger abscess	1.54	5.58	1.63	0.18	7.30	3.35	010
26011	.....	A	Drainage of finger abscess	2.19	8.84	2.33	0.33	11.36	4.85	010
26020	.....	A	Drain hand tendon sheath	4.66	NA	5.37	0.73	NA	10.76	090
26025	.....	A	Drainage of palm bursa	4.81	NA	5.13	0.76	NA	10.70	090
26030	.....	A	Drainage of palm bursa(s)	5.92	NA	5.74	0.92	NA	12.58	090
26034	.....	A	Treat hand bone lesion	6.22	NA	6.37	1.01	NA	13.60	090
26035	.....	A	Decompress fingers/hand	9.50	NA	7.89	1.47	NA	18.86	090
26037	.....	A	Decompress fingers/hand	7.24	NA	6.34	1.13	NA	14.71	090
26040	.....	A	Release palm contracture	3.33	NA	4.06	0.53	NA	7.92	090
26045	.....	A	Release palm contracture	5.55	NA	5.66	0.93	NA	12.14	090
26055	.....	A	Incise finger tendon sheath	2.69	14.39	3.95	0.43	17.51	7.07	090
26060	.....	A	Incision of finger tendon	2.81	NA	3.52	0.45	NA	6.78	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
26070	.....	A	Explore/treat hand joint	3.68	NA	3.37	0.48	NA	7.53	090
26075	.....	A	Explore/treat finger joint	3.78	NA	3.79	0.53	NA	8.10	090
26080	.....	A	Explore/treat finger joint	4.23	NA	4.86	0.66	NA	9.75	090
26100	.....	A	Biopsy hand joint lining	3.66	NA	4.14	0.54	NA	8.34	090
26105	.....	A	Biopsy finger joint lining	3.70	NA	4.24	0.59	NA	8.53	090
26110	.....	A	Biopsy finger joint lining	3.52	NA	4.05	0.53	NA	8.10	090
26115	.....	A	Removal hand lesion subcut	3.85	13.13	4.78	0.59	17.57	9.22	090
26116	.....	A	Removal hand lesion, deep	5.52	NA	6.02	0.84	NA	12.38	090
26117	.....	A	Remove tumor, hand/finger	8.54	NA	7.08	1.26	NA	16.88	090
26121	.....	A	Release palm contracture	7.53	NA	6.98	1.17	NA	15.68	090
26123	.....	A	Release palm contracture	9.28	NA	8.88	1.43	NA	19.59	090
26125	.....	A	Release palm contracture	4.60	NA	2.45	0.70	NA	7.75	ZZZ
26130	.....	A	Remove wrist joint lining	5.41	NA	5.36	0.94	NA	11.71	090
26135	.....	A	Revise finger joint, each	6.95	NA	6.48	1.07	NA	14.50	090
26140	.....	A	Revise finger joint, each	6.16	NA	6.06	0.92	NA	13.14	090
26145	.....	A	Tendon excision, palm/finger	6.31	NA	6.07	0.97	NA	13.35	090
26160	.....	A	Remove tendon sheath lesion	3.15	12.41	4.13	0.49	16.05	7.77	090
26170	.....	A	Removal of palm tendon, each	4.76	NA	4.95	0.69	NA	10.40	090
26180	.....	A	Removal of finger tendon	5.17	NA	5.43	0.78	NA	11.38	090
26185	.....	A	Remove finger bone	5.24	NA	6.05	0.81	NA	12.10	090
26200	.....	A	Remove hand bone lesion	5.50	NA	5.37	0.88	NA	11.75	090
26205	.....	A	Remove/graft bone lesion	7.69	NA	6.91	1.20	NA	15.80	090
26210	.....	A	Removal of finger lesion	5.14	NA	5.44	0.79	NA	11.37	090
26215	.....	A	Remove/graft finger lesion	7.09	NA	6.33	0.98	NA	14.40	090
26230	.....	A	Partial removal of hand bone	6.32	NA	5.93	1.01	NA	13.26	090
26235	.....	A	Partial removal, finger bone	6.18	NA	5.83	0.95	NA	12.96	090
26236	.....	A	Partial removal, finger bone	5.31	NA	5.34	0.81	NA	11.46	090
26250	.....	A	Extensive hand surgery	7.54	NA	6.45	1.07	NA	15.06	090
26255	.....	A	Extensive hand surgery	12.41	NA	9.40	1.68	NA	23.49	090
26260	.....	A	Extensive finger surgery	7.02	NA	6.20	1.01	NA	14.23	090
26261	.....	A	Extensive finger surgery	9.08	NA	6.19	1.14	NA	16.41	090
26262	.....	A	Partial removal of finger	5.66	NA	5.35	0.88	NA	11.89	090
26320	.....	A	Removal of implant from hand	3.97	NA	4.32	0.59	NA	8.88	090
26340	.....	A	Manipulate finger w/anesth	2.50	NA	4.89	0.39	NA	7.78	090
26350	.....	A	Repair finger/hand tendon	5.98	NA	14.65	0.93	NA	21.56	090
26352	.....	A	Repair/graft hand tendon	7.67	NA	15.40	1.13	NA	24.20	090
26356	.....	A	Repair finger/hand tendon	8.06	NA	18.42	1.21	NA	27.69	090
26357	.....	A	Repair finger/hand tendon	8.57	NA	15.68	1.33	NA	25.58	090
26358	.....	A	Repair/graft hand tendon	9.13	NA	16.69	1.38	NA	27.20	090
26370	.....	A	Repair finger/hand tendon	7.10	NA	15.15	1.12	NA	23.37	090
26372	.....	A	Repair/graft hand tendon	8.75	NA	16.58	1.40	NA	26.73	090
26373	.....	A	Repair finger/hand tendon	8.15	NA	16.09	1.23	NA	25.47	090
26390	.....	A	Revise hand/finger tendon	9.18	NA	13.32	1.40	NA	23.90	090
26392	.....	A	Repair/graft hand tendon	10.24	NA	16.77	1.57	NA	28.58	090
26410	.....	A	Repair hand tendon	4.62	NA	11.97	0.73	NA	17.32	090
26412	.....	A	Repair/graft hand tendon	6.30	NA	13.31	0.97	NA	20.58	090
26415	.....	A	Excision, hand/finger tendon	8.33	NA	11.81	0.98	NA	21.12	090
26416	.....	A	Graft hand or finger tendon	9.36	NA	14.63	0.79	NA	24.78	090
26418	.....	A	Repair finger tendon	4.24	NA	12.36	0.67	NA	17.27	090
26420	.....	A	Repair/graft finger tendon	6.76	NA	13.67	1.07	NA	21.50	090
26426	.....	A	Repair finger/hand tendon	6.14	NA	13.20	0.95	NA	20.29	090
26428	.....	A	Repair/graft finger tendon	7.20	NA	13.90	1.09	NA	22.19	090
26432	.....	A	Repair finger tendon	4.01	NA	10.29	0.64	NA	14.94	090
26433	.....	A	Repair finger tendon	4.55	NA	10.82	0.72	NA	16.09	090
26434	.....	A	Repair/graft finger tendon	6.08	NA	11.57	0.93	NA	18.58	090
26437	.....	A	Realignment of tendons	5.81	NA	11.60	0.89	NA	18.30	090
26440	.....	A	Release palm/finger tendon	5.01	NA	13.47	0.75	NA	19.23	090
26442	.....	A	Release palm & finger tendon	8.15	NA	15.99	1.20	NA	25.34	090
26445	.....	A	Release hand/finger tendon	4.30	NA	13.18	0.65	NA	18.13	090
26449	.....	A	Release forearm/hand tendon	6.99	NA	15.82	1.06	NA	23.87	090
26450	.....	A	Incision of palm tendon	3.66	NA	7.35	0.59	NA	11.60	090
26455	.....	A	Incision of finger tendon	3.63	NA	7.30	0.58	NA	11.51	090
26460	.....	A	Incise hand/finger tendon	3.45	NA	7.16	0.55	NA	11.16	090
26471	.....	A	Fusion of finger tendons	5.72	NA	11.27	0.88	NA	17.87	090
26474	.....	A	Fusion of finger tendons	5.31	NA	11.42	0.76	NA	17.49	090
26476	.....	A	Tendon lengthening	5.17	NA	10.96	0.79	NA	16.92	090
26477	.....	A	Tendon shortening	5.14	NA	11.09	0.81	NA	17.04	090
26478	.....	A	Lengthening of hand tendon	5.79	NA	11.87	0.90	NA	18.56	090
26479	.....	A	Shortening of hand tendon	5.73	NA	11.59	0.92	NA	18.24	090
26480	.....	A	Transplant hand tendon	6.68	NA	15.08	1.02	NA	22.78	090
26483	.....	A	Transplant/graft hand tendon	8.28	NA	15.54	1.26	NA	25.08	090
26485	.....	A	Transplant palm tendon	7.69	NA	15.40	1.15	NA	24.24	090
26489	.....	A	Transplant/graft palm tendon	9.54	NA	12.09	1.26	NA	22.89	090
26490	.....	A	Revise thumb tendon	8.40	NA	12.86	1.21	NA	22.47	090
26492	.....	A	Tendon transfer with graft	9.61	NA	13.64	1.40	NA	24.65	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
26494	.....	A	Hand tendon/muscle transfer	8.46	NA	13.01	1.28	NA	22.75	090
26496	.....	A	Revise thumb tendon	9.58	NA	13.27	1.45	NA	24.30	090
26497	.....	A	Finger tendon transfer	9.56	NA	13.61	1.41	NA	24.58	090
26498	.....	A	Finger tendon transfer	13.98	NA	16.21	2.10	NA	32.29	090
26499	.....	A	Revision of finger	8.97	NA	13.08	1.35	NA	23.40	090
26500	.....	A	Hand tendon reconstruction	5.95	NA	11.47	0.90	NA	18.32	090
26502	.....	A	Hand tendon reconstruction	7.13	NA	12.05	1.13	NA	20.31	090
26504	.....	A	Hand tendon reconstruction	7.46	NA	12.62	1.24	NA	21.32	090
26508	.....	A	Release thumb contracture	6.00	NA	11.71	0.98	NA	18.69	090
26510	.....	A	Thumb tendon transfer	5.42	NA	11.37	0.79	NA	17.58	090
26516	.....	A	Fusion of knuckle joint	7.14	NA	12.27	1.10	NA	20.51	090
26517	.....	A	Fusion of knuckle joints	8.82	NA	13.54	1.41	NA	23.77	090
26518	.....	A	Fusion of knuckle joints	9.01	NA	13.43	1.35	NA	23.79	090
26520	.....	A	Release knuckle contracture	5.29	NA	13.93	0.80	NA	20.02	090
26525	.....	A	Release finger contracture	5.32	NA	14.01	0.81	NA	20.14	090
26530	.....	A	Revise knuckle joint	6.68	NA	6.16	1.04	NA	13.88	090
26531	.....	A	Revise knuckle with implant	7.90	NA	7.14	1.17	NA	16.21	090
26535	.....	A	Revise finger joint	5.23	NA	3.75	0.71	NA	9.69	090
26536	.....	A	Revise/implant finger joint	6.36	NA	9.68	0.96	NA	17.00	090
26540	.....	A	Repair hand joint	6.42	NA	11.90	0.99	NA	19.31	090
26541	.....	A	Repair hand joint with graft	8.61	NA	13.43	1.28	NA	23.32	090
26542	.....	A	Repair hand joint with graft	6.77	NA	12.06	1.02	NA	19.85	090
26545	.....	A	Reconstruct finger joint	6.91	NA	12.17	1.05	NA	20.13	090
26546	.....	A	Repair nonunion hand	8.91	NA	15.07	1.44	NA	25.42	090
26548	.....	A	Reconstruct finger joint	8.02	NA	12.89	1.20	NA	22.11	090
26550	.....	A	Construct thumb replacement	21.21	NA	17.63	2.45	NA	41.29	090
26551	.....	A	Great toe-hand transfer	46.51	NA	32.53	7.96	NA	87.00	090
26553	.....	A	Single transfer, toe-hand	46.20	NA	22.75	2.41	NA	71.36	090
26554	.....	A	Double transfer, toe-hand	54.87	NA	37.64	9.41	NA	101.92	090
26555	.....	A	Positional change of finger	16.61	NA	18.23	2.48	NA	37.32	090
26556	.....	A	Toe joint transfer	47.19	NA	33.42	2.57	NA	83.18	090
26560	.....	A	Repair of web finger	5.37	NA	9.83	0.85	NA	16.05	090
26561	.....	A	Repair of web finger	10.90	NA	12.38	1.45	NA	24.73	090
26562	.....	A	Repair of web finger	14.98	NA	17.19	2.23	NA	34.40	090
26565	.....	A	Correct metacarpal flaw	6.73	NA	12.04	1.00	NA	19.77	090
26567	.....	A	Correct finger deformity	6.81	NA	11.98	1.04	NA	19.83	090
26568	.....	A	Lengthen metacarpal/finger	9.07	NA	15.47	1.49	NA	26.03	090
26580	.....	A	Repair hand deformity	18.15	NA	13.68	2.28	NA	34.11	090
26587	.....	A	Reconstruct extra finger	14.03	NA	9.24	1.53	NA	24.80	090
26590	.....	A	Repair finger deformity	17.93	NA	13.98	2.77	NA	34.68	090
26591	.....	A	Repair muscles of hand	3.25	NA	9.65	0.48	NA	13.38	090
26593	.....	A	Release muscles of hand	5.30	NA	11.16	0.78	NA	17.24	090
26596	.....	A	Excision constricting tissue	8.94	NA	8.85	1.43	NA	19.22	090
26600	.....	A	Treat metacarpal fracture	1.96	3.62	2.66	0.30	5.88	4.92	090
26605	.....	A	Treat metacarpal fracture	2.85	4.57	3.66	0.49	7.91	7.00	090
26607	.....	A	Treat metacarpal fracture	5.35	NA	6.29	0.87	NA	12.51	090
26608	.....	A	Treat metacarpal fracture	5.35	NA	6.27	0.88	NA	12.50	090
26615	.....	A	Treat metacarpal fracture	5.32	NA	5.32	0.86	NA	11.50	090
26641	.....	A	Treat thumb dislocation	3.93	4.58	3.54	0.39	8.90	7.86	090
26645	.....	A	Treat thumb fracture	4.40	5.18	4.20	0.67	10.25	9.27	090
26650	.....	A	Treat thumb fracture	5.71	NA	6.71	0.94	NA	13.36	090
26665	.....	A	Treat thumb fracture	7.59	NA	6.63	0.90	NA	15.12	090
26670	.....	A	Treat hand dislocation	3.68	4.27	2.95	0.39	8.34	7.02	090
26675	.....	A	Treat hand dislocation	4.63	5.49	4.48	0.77	10.89	9.88	090
26676	.....	A	Pin hand dislocation	5.51	NA	6.71	0.91	NA	13.13	090
26685	.....	A	Treat hand dislocation	6.97	NA	6.16	1.09	NA	14.22	090
26686	.....	A	Treat hand dislocation	7.93	NA	6.92	1.24	NA	16.09	090
26700	.....	A	Treat knuckle dislocation	3.68	3.77	2.87	0.35	7.80	6.90	090
26705	.....	A	Treat knuckle dislocation	4.18	5.35	4.31	0.66	10.19	9.15	090
26706	.....	A	Pin knuckle dislocation	5.11	NA	5.10	0.81	NA	11.02	090
26715	.....	A	Treat knuckle dislocation	5.73	NA	5.53	0.91	NA	12.17	090
26720	.....	A	Treat finger fracture, each	1.66	2.79	2.06	0.24	4.69	3.96	090
26725	.....	A	Treat finger fracture, each	3.33	4.78	3.51	0.53	8.64	7.37	090
26727	.....	A	Treat finger fracture, each	5.22	NA	6.25	0.84	NA	12.31	090
26735	.....	A	Treat finger fracture, each	5.97	NA	5.57	0.95	NA	12.49	090
26740	.....	A	Treat finger fracture, each	1.94	3.14	2.71	0.31	5.39	4.96	090
26742	.....	A	Treat finger fracture, each	3.84	5.00	3.89	0.58	9.42	8.31	090
26746	.....	A	Treat finger fracture, each	5.80	NA	5.58	0.91	NA	12.29	090
26750	.....	A	Treat finger fracture, each	1.70	2.49	2.02	0.22	4.41	3.94	090
26755	.....	A	Treat finger fracture, each	3.10	4.43	3.01	0.42	7.95	6.53	090
26756	.....	A	Pin finger fracture, each	4.38	NA	5.74	0.71	NA	10.83	090
26765	.....	A	Treat finger fracture, each	4.16	NA	4.40	0.66	NA	9.22	090
26770	.....	A	Treat finger dislocation	3.02	3.44	2.42	0.27	6.73	5.71	090
26775	.....	A	Treat finger dislocation	3.70	5.21	3.82	0.54	9.45	8.06	090
26776	.....	A	Pin finger dislocation	4.79	NA	6.02	0.77	NA	11.58	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
26785	.....	A	Treat finger dislocation	4.20	NA	4.54	0.68	NA	9.42	090
26820	.....	A	Thumb fusion with graft	8.25	NA	13.29	1.30	NA	22.84	090
26841	.....	A	Fusion of thumb	7.12	NA	13.27	1.18	NA	21.57	090
26842	.....	A	Thumb fusion with graft	8.23	NA	13.41	1.32	NA	22.96	090
26843	.....	A	Fusion of hand joint	7.60	NA	12.39	1.15	NA	21.14	090
26844	.....	A	Fusion/graft of hand joint	8.72	NA	13.40	1.33	NA	23.45	090
26850	.....	A	Fusion of knuckle	6.96	NA	12.24	1.06	NA	20.26	090
26852	.....	A	Fusion of knuckle with graft	8.45	NA	12.93	1.22	NA	22.60	090
26860	.....	A	Fusion of finger joint	4.68	NA	11.22	0.73	NA	16.63	090
26861	.....	A	Fusion of finger jnt, add-on	1.74	NA	0.93	0.27	NA	2.94	ZZZ
26862	.....	A	Fusion/graft of finger joint	7.36	NA	12.38	1.10	NA	20.84	090
26863	.....	A	Fuse/graft added joint	3.89	NA	2.12	0.56	NA	6.57	ZZZ
26910	.....	A	Amputate metacarpal bone	7.59	NA	11.25	1.16	NA	20.00	090
26951	.....	A	Amputation of finger/thumb	4.58	NA	10.18	0.71	NA	15.47	090
26952	.....	A	Amputation of finger/thumb	6.30	NA	11.69	0.95	NA	18.94	090
26989	.....	C	Hand/finger surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
26990	.....	A	Drainage of pelvis lesion	7.47	NA	7.23	1.22	NA	15.92	090
26991	.....	A	Drainage of pelvis bursa	6.67	11.19	5.45	1.11	18.97	13.23	090
26992	.....	A	Drainage of bone lesion	13.00	NA	10.41	2.16	NA	25.57	090
27000	.....	A	Incision of hip tendon	5.61	NA	5.30	0.98	NA	11.89	090
27001	.....	A	Incision of hip tendon	6.93	NA	6.11	1.24	NA	14.28	090
27003	.....	A	Incision of hip tendon	7.33	NA	6.50	1.12	NA	14.95	090
27005	.....	A	Incision of hip tendon	9.65	NA	7.84	1.72	NA	19.21	090
27006	.....	A	Incision of hip tendons	9.67	NA	8.00	1.69	NA	19.36	090
27025	.....	A	Incision of hip/thigh fascia	11.14	NA	8.57	1.84	NA	21.55	090
27030	.....	A	Drainage of hip joint	12.99	NA	9.67	2.26	NA	24.92	090
27033	.....	A	Exploration of hip joint	13.37	NA	9.95	2.32	NA	25.64	090
27035	.....	A	Denervation of hip joint	16.66	NA	11.26	2.15	NA	30.07	090
27036	.....	A	Excision of hip joint/muscle	12.86	NA	10.03	2.26	NA	25.15	090
27040	.....	A	Biopsy of soft tissues	2.87	5.25	2.02	0.27	8.39	5.16	010
27041	.....	A	Biopsy of soft tissues	9.88	NA	6.66	1.35	NA	17.89	090
27047	.....	A	Remove hip/pelvis lesion	7.44	7.13	4.78	1.03	15.60	13.25	090
27048	.....	A	Remove hip/pelvis lesion	6.24	NA	4.81	0.92	NA	11.97	090
27049	.....	A	Remove tumor, hip/pelvis	13.64	NA	8.42	2.06	NA	24.12	090
27050	.....	A	Biopsy of sacroiliac joint	4.35	NA	4.43	0.60	NA	9.38	090
27052	.....	A	Biopsy of hip joint	6.22	NA	5.90	1.08	NA	13.20	090
27054	.....	A	Removal of hip joint lining	8.53	NA	7.36	1.47	NA	17.36	090
27060	.....	A	Removal of ischial bursa	5.42	NA	4.38	0.80	NA	10.60	090
27062	.....	A	Remove femur lesion/bursa	5.36	NA	5.21	0.93	NA	11.50	090
27065	.....	A	Removal of hip bone lesion	5.89	NA	5.46	1.01	NA	12.36	090
27066	.....	A	Removal of hip bone lesion	10.31	NA	8.46	1.79	NA	20.56	090
27067	.....	A	Remove/graft hip bone lesion	13.81	NA	10.69	1.84	NA	26.34	090
27070	.....	A	Partial removal of hip bone	10.70	NA	9.16	1.74	NA	21.60	090
27071	.....	A	Partial removal of hip bone	11.44	NA	10.15	1.92	NA	23.51	090
27075	.....	A	Extensive hip surgery	34.95	NA	19.26	5.64	NA	59.85	090
27076	.....	A	Extensive hip surgery	22.09	NA	14.55	3.70	NA	40.34	090
27077	.....	A	Extensive hip surgery	39.94	NA	22.73	6.12	NA	68.79	090
27078	.....	A	Extensive hip surgery	13.42	NA	9.97	2.22	NA	25.61	090
27079	.....	A	Extensive hip surgery	13.73	NA	9.57	1.94	NA	25.24	090
27080	.....	A	Removal of tail bone	6.38	NA	4.84	0.93	NA	12.15	090
27086	.....	A	Remove hip foreign body	1.87	4.56	1.83	0.25	6.68	3.95	010
27087	.....	A	Remove hip foreign body	8.53	NA	6.68	1.35	NA	16.56	090
27090	.....	A	Removal of hip prosthesis	11.13	NA	8.81	1.94	NA	21.88	090
27091	.....	A	Removal of hip prosthesis	22.11	NA	14.03	3.84	NA	39.98	090
27093	.....	A	Injection for hip x-ray	1.30	4.47	0.48	0.13	5.90	1.91	000
27095	.....	A	Injection for hip x-ray	1.50	5.74	0.52	0.14	7.38	2.16	000
27096	.....	A	Inject sacroiliac joint	1.40	4.36	0.33	0.08	5.84	1.81	000
27097	.....	A	Revision of hip tendon	8.79	NA	6.43	1.57	NA	16.79	090
27098	.....	A	Transfer tendon to pelvis	8.82	NA	7.04	0.95	NA	16.81	090
27100	.....	A	Transfer of abdominal muscle	11.06	NA	8.69	1.85	NA	21.60	090
27105	.....	A	Transfer of spinal muscle	11.75	NA	9.19	1.72	NA	22.66	090
27110	.....	A	Transfer of iliopsoas muscle	13.24	NA	9.14	2.18	NA	24.56	090
27111	.....	A	Transfer of iliopsoas muscle	12.13	NA	9.16	1.94	NA	23.23	090
27120	.....	A	Reconstruction of hip socket	17.98	NA	11.87	3.08	NA	32.93	090
27122	.....	A	Reconstruction of hip socket	14.96	NA	11.07	2.61	NA	28.64	090
27125	.....	A	Partial hip replacement	14.67	NA	10.65	2.54	NA	27.86	090
27130	.....	A	Total hip arthroplasty	20.09	NA	13.34	3.50	NA	36.93	090
27132	.....	A	Total hip arthroplasty	23.27	NA	15.68	4.04	NA	42.99	090
27134	.....	A	Revise hip joint replacement	28.48	NA	17.84	4.94	NA	51.26	090
27137	.....	A	Revise hip joint replacement	21.14	NA	13.97	3.67	NA	38.78	090
27138	.....	A	Revise hip joint replacement	22.14	NA	14.43	3.84	NA	40.41	090
27140	.....	A	Transplant femur ridge	12.22	NA	9.44	2.11	NA	23.77	090
27146	.....	A	Incision of hip bone	17.40	NA	12.17	2.96	NA	32.53	090
27147	.....	A	Revision of hip bone	20.55	NA	13.29	3.57	NA	37.41	090
27151	.....	A	Incision of hip bones	22.48	NA	7.97	3.91	NA	34.36	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
27156	.....	A	Revision of hip bones	24.59	NA	16.11	4.21	NA	44.91	090
27158	.....	A	Revision of pelvis	19.71	NA	11.00	3.16	NA	33.87	090
27161	.....	A	Incision of neck of femur	16.68	NA	12.14	2.94	NA	31.76	090
27165	.....	A	Incision/fixation of femur	17.88	NA	12.95	3.10	NA	33.93	090
27170	.....	A	Repair/graft femur head/neck	16.05	NA	11.33	2.81	NA	30.19	090
27175	.....	A	Treat slipped epiphysis	8.45	NA	6.69	1.46	NA	16.60	090
27176	.....	A	Treat slipped epiphysis	12.03	NA	9.04	2.22	NA	23.29	090
27177	.....	A	Treat slipped epiphysis	15.06	NA	10.92	2.61	NA	28.59	090
27178	.....	A	Treat slipped epiphysis	11.97	NA	8.44	2.08	NA	22.49	090
27179	.....	A	Revise head/neck of femur	12.96	NA	10.02	2.25	NA	25.23	090
27181	.....	A	Treat slipped epiphysis	14.66	NA	10.23	1.57	NA	26.46	090
27185	.....	A	Revision of femur epiphysis	9.17	NA	7.54	2.39	NA	19.10	090
27187	.....	A	Reinforce hip bones	13.52	NA	10.35	2.37	NA	26.24	090
27193	.....	A	Treat pelvic ring fracture	5.55	5.10	5.10	0.96	11.61	11.61	090
27194	.....	A	Treat pelvic ring fracture	9.64	NA	7.67	1.65	NA	18.96	090
27200	.....	A	Treat tail bone fracture	1.84	2.23	2.16	0.28	4.35	4.28	090
27202	.....	A	Treat tail bone fracture	7.03	NA	16.91	1.06	NA	25.00	090
27215	.....	A	Treat pelvic fracture(s)	10.03	NA	7.10	1.97	NA	19.10	090
27216	.....	A	Treat pelvic ring fracture	15.17	NA	9.62	2.63	NA	27.42	090
27217	.....	A	Treat pelvic ring fracture	14.09	NA	10.17	2.41	NA	26.67	090
27218	.....	A	Treat pelvic ring fracture	20.12	NA	11.43	3.48	NA	35.03	090
27220	.....	A	Treat hip socket fracture	6.17	5.74	5.65	1.07	12.98	12.89	090
27222	.....	A	Treat hip socket fracture	12.68	NA	10.00	2.19	NA	24.87	090
27226	.....	A	Treat hip wall fracture	14.89	NA	7.83	2.48	NA	25.20	090
27227	.....	A	Treat hip fracture(s)	23.41	NA	15.44	4.05	NA	42.90	090
27228	.....	A	Treat hip fracture(s)	27.12	NA	17.67	4.66	NA	49.45	090
27230	.....	A	Treat thigh fracture	5.49	5.53	5.11	0.95	11.97	11.55	090
27232	.....	A	Treat thigh fracture	10.66	NA	7.19	1.85	NA	19.70	090
27235	.....	A	Treat thigh fracture	12.14	NA	9.48	2.11	NA	23.73	090
27236	.....	A	Treat thigh fracture	15.58	NA	11.08	2.71	NA	29.37	090
27238	.....	A	Treat thigh fracture	5.51	NA	5.15	0.89	NA	11.55	090
27240	.....	A	Treat thigh fracture	12.48	NA	9.50	2.16	NA	24.14	090
27244	.....	A	Treat thigh fracture	15.92	NA	11.33	2.77	NA	30.02	090
27245	.....	A	Treat thigh fracture	20.28	NA	13.78	3.52	NA	37.58	090
27246	.....	A	Treat thigh fracture	4.70	4.47	4.43	0.81	9.98	9.94	090
27248	.....	A	Treat thigh fracture	10.43	NA	8.23	1.81	NA	20.47	090
27250	.....	A	Treat hip dislocation	6.94	NA	4.63	0.62	NA	12.19	090
27252	.....	A	Treat hip dislocation	10.37	NA	7.45	1.66	NA	19.48	090
27253	.....	A	Treat hip dislocation	12.90	NA	9.81	2.24	NA	24.95	090
27254	.....	A	Treat hip dislocation	18.23	NA	12.05	3.17	NA	33.45	090
27256	.....	A	Treat hip dislocation	4.11	3.53	2.09	0.46	8.10	6.66	010
27257	.....	A	Treat hip dislocation	5.21	NA	2.82	0.69	NA	8.72	010
27258	.....	A	Treat hip dislocation	15.41	NA	10.90	2.64	NA	28.95	090
27259	.....	A	Treat hip dislocation	21.52	NA	14.16	3.74	NA	39.42	090
27265	.....	A	Treat hip dislocation	5.04	NA	4.80	0.63	NA	10.47	090
27266	.....	A	Treat hip dislocation	7.48	NA	6.36	1.29	NA	15.13	090
27275	.....	A	Manipulation of hip joint	2.27	NA	2.11	0.39	NA	4.77	010
27280	.....	A	Fusion of sacroiliac joint	13.37	NA	10.29	2.53	NA	26.19	090
27282	.....	A	Fusion of pubic bones	11.32	NA	8.02	1.86	NA	21.20	090
27284	.....	A	Fusion of hip joint	23.41	NA	14.80	3.92	NA	42.13	090
27286	.....	A	Fusion of hip joint	23.41	NA	15.84	3.12	NA	42.37	090
27290	.....	A	Amputation of leg at hip	23.25	NA	14.10	3.43	NA	40.78	090
27295	.....	A	Amputation of leg at hip	18.62	NA	11.34	2.95	NA	32.91	090
27299	.....	C	Pelvis/hip joint surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
27301	.....	A	Drain thigh/knee lesion	6.48	10.10	5.15	1.04	17.62	12.67	090
27303	.....	A	Drainage of bone lesion	8.27	NA	7.00	1.43	NA	16.70	090
27305	.....	A	Incise thigh tendon & fascia	5.91	NA	5.20	1.01	NA	12.12	090
27306	.....	A	Incision of thigh tendon	4.61	NA	4.73	0.85	NA	10.19	090
27307	.....	A	Incision of thigh tendons	5.79	NA	5.40	1.04	NA	12.23	090
27310	.....	A	Exploration of knee joint	9.26	NA	7.60	1.61	NA	18.47	090
27315	.....	A	Partial removal, thigh nerve	6.96	NA	4.96	1.09	NA	13.01	090
27320	.....	A	Partial removal, thigh nerve	6.29	NA	5.25	1.06	NA	12.60	090
27323	.....	A	Biopsy, thigh soft tissues	2.28	3.52	1.89	0.24	6.04	4.41	010
27324	.....	A	Biopsy, thigh soft tissues	4.89	NA	4.19	0.75	NA	9.83	090
27327	.....	A	Removal of thigh lesion	4.46	6.01	3.73	0.64	11.11	8.83	090
27328	.....	A	Removal of thigh lesion	5.56	NA	4.38	0.84	NA	10.78	090
27329	.....	A	Remove tumor, thigh/knee	14.12	NA	9.05	2.14	NA	25.31	090
27330	.....	A	Biopsy, knee joint lining	4.96	NA	4.58	0.86	NA	10.40	090
27331	.....	A	Explore/treat knee joint	5.87	NA	5.54	1.02	NA	12.43	090
27332	.....	A	Removal of knee cartilage	8.26	NA	7.14	1.43	NA	16.83	090
27333	.....	A	Removal of knee cartilage	7.29	NA	6.69	1.26	NA	15.24	090
27334	.....	A	Remove knee joint lining	8.69	NA	7.43	1.51	NA	17.63	090
27335	.....	A	Remove knee joint lining	9.99	NA	8.24	1.74	NA	19.97	090
27340	.....	A	Removal of kneecap bursa	4.17	NA	4.57	0.72	NA	9.46	090
27345	.....	A	Removal of knee cyst	5.91	NA	5.64	1.00	NA	12.55	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
27347	.....	A	Remove knee cyst	5.77	NA	5.44	0.98	NA	12.19	090
27350	.....	A	Removal of kneecap	8.16	NA	7.26	1.41	NA	16.83	090
27355	.....	A	Remove femur lesion	7.64	NA	6.79	1.32	NA	15.75	090
27356	.....	A	Remove femur lesion/graft	9.47	NA	7.87	1.65	NA	18.99	090
27357	.....	A	Remove femur lesion/graft	10.51	NA	8.73	1.95	NA	21.19	090
27358	.....	A	Remove femur lesion/fixation	4.73	NA	2.53	0.82	NA	8.08	ZZZ
27360	.....	A	Partial removal, leg bone(s)	10.48	NA	9.58	1.83	NA	21.89	090
27365	.....	A	Extensive leg surgery	16.25	NA	11.71	2.79	NA	30.75	090
27370	.....	A	Injection for knee x-ray	0.96	3.73	0.32	0.08	4.77	1.36	000
27372	.....	A	Removal of foreign body	5.06	10.08	4.70	0.84	15.98	10.60	090
27380	.....	A	Repair of kneecap tendon	7.15	NA	7.30	1.24	NA	15.69	090
27381	.....	A	Repair/graft kneecap tendon	10.32	NA	9.12	1.79	NA	21.23	090
27385	.....	A	Repair of thigh muscle	7.75	NA	7.65	1.36	NA	16.76	090
27386	.....	A	Repair/graft of thigh muscle	10.54	NA	9.54	1.85	NA	21.93	090
27390	.....	A	Incision of thigh tendon	5.32	NA	5.12	0.92	NA	11.36	090
27391	.....	A	Incision of thigh tendons	7.19	NA	6.58	1.23	NA	15.00	090
27392	.....	A	Incision of thigh tendons	9.19	NA	7.61	1.57	NA	18.37	090
27393	.....	A	Lengthening of thigh tendon	6.38	NA	5.85	1.10	NA	13.33	090
27394	.....	A	Lengthening of thigh tendons	8.49	NA	7.24	1.47	NA	17.20	090
27395	.....	A	Lengthening of thigh tendons	11.71	NA	9.35	2.04	NA	23.10	090
27396	.....	A	Transplant of thigh tendon	7.85	NA	7.02	1.34	NA	16.21	090
27397	.....	A	Transplants of thigh tendons	11.26	NA	9.07	1.82	NA	22.15	090
27400	.....	A	Revise thigh muscles/tendons	9.01	NA	7.27	1.31	NA	17.59	090
27403	.....	A	Repair of knee cartilage	8.32	NA	7.20	1.44	NA	16.96	090
27405	.....	A	Repair of knee ligament	8.64	NA	7.51	1.51	NA	17.66	090
27407	.....	A	Repair of knee ligament	10.26	NA	8.34	1.78	NA	20.38	090
27409	.....	A	Repair of knee ligaments	12.88	NA	9.98	2.24	NA	25.10	090
27412	.....	A	Autochondrocyte implant knee	23.23	NA	14.84	4.35	NA	42.42	090
27415	.....	A	Osteochondral knee allograft	18.49	NA	12.59	4.35	NA	35.43	090
27418	.....	A	Repair degenerated kneecap	10.83	NA	8.93	1.88	NA	21.64	090
27420	.....	A	Revision of unstable kneecap	9.82	NA	8.13	1.71	NA	19.66	090
27422	.....	A	Revision of unstable kneecap	9.77	NA	8.14	1.70	NA	19.61	090
27424	.....	A	Revision/removal of kneecap	9.80	NA	8.11	1.70	NA	19.61	090
27425	.....	A	Lat retinacular release open	5.21	NA	5.54	0.90	NA	11.65	090
27427	.....	A	Reconstruction, knee	9.35	NA	7.82	1.63	NA	18.80	090
27428	.....	A	Reconstruction, knee	13.98	NA	11.27	2.42	NA	27.67	090
27429	.....	A	Reconstruction, knee	15.50	NA	12.45	2.70	NA	30.65	090
27430	.....	A	Revision of thigh muscles	9.66	NA	8.02	1.69	NA	19.37	090
27435	.....	A	Incision of knee joint	9.48	NA	8.50	1.69	NA	19.67	090
27437	.....	A	Revise kneecap	8.45	NA	7.26	1.49	NA	17.20	090
27438	.....	A	Revise kneecap with implant	11.21	NA	8.56	1.95	NA	21.72	090
27440	.....	A	Revision of knee joint	10.41	NA	6.01	1.81	NA	18.23	090
27441	.....	A	Revision of knee joint	10.80	NA	6.73	1.88	NA	19.41	090
27442	.....	A	Revision of knee joint	11.87	NA	8.94	2.09	NA	22.90	090
27443	.....	A	Revision of knee joint	10.91	NA	8.75	1.90	NA	21.56	090
27445	.....	A	Revision of knee joint	17.65	NA	12.39	3.08	NA	33.12	090
27446	.....	A	Revision of knee joint	15.82	NA	11.30	2.80	NA	29.92	090
27447	.....	A	Total knee arthroplasty	21.45	NA	14.64	3.79	NA	39.88	090
27448	.....	A	Incision of thigh	11.04	NA	8.62	1.94	NA	21.60	090
27450	.....	A	Incision of thigh	13.96	NA	10.61	2.42	NA	26.99	090
27454	.....	A	Realignment of thigh bone	17.53	NA	12.54	3.12	NA	33.19	090
27455	.....	A	Realignment of knee	12.80	NA	9.91	2.24	NA	24.95	090
27457	.....	A	Realignment of knee	13.43	NA	9.95	2.34	NA	25.72	090
27465	.....	A	Shortening of thigh bone	13.85	NA	10.25	2.47	NA	26.57	090
27466	.....	A	Lengthening of thigh bone	16.31	NA	11.86	2.77	NA	30.94	090
27468	.....	A	Shorten/lengthen thighs	18.94	NA	12.39	3.30	NA	34.63	090
27470	.....	A	Repair of thigh	16.05	NA	11.82	2.79	NA	30.66	090
27472	.....	A	Repair/graft of thigh	17.69	NA	12.72	3.07	NA	33.48	090
27475	.....	A	Surgery to stop leg growth	8.63	NA	7.23	1.36	NA	17.22	090
27477	.....	A	Surgery to stop leg growth	9.84	NA	7.75	1.73	NA	19.32	090
27479	.....	A	Surgery to stop leg growth	12.78	NA	9.67	2.78	NA	25.23	090
27485	.....	A	Surgery to stop leg growth	8.83	NA	7.42	1.53	NA	17.78	090
27486	.....	A	Revise/replace knee joint	19.24	NA	13.53	3.36	NA	36.13	090
27487	.....	A	Revise/replace knee joint	25.23	NA	16.60	4.39	NA	46.22	090
27488	.....	A	Removal of knee prosthesis	15.72	NA	11.73	2.74	NA	30.19	090
27495	.....	A	Reinforce thigh	15.53	NA	11.44	2.71	NA	29.68	090
27496	.....	A	Decompression of thigh/knee	6.10	NA	5.62	0.99	NA	12.71	090
27497	.....	A	Decompression of thigh/knee	7.16	NA	5.45	1.15	NA	13.76	090
27498	.....	A	Decompression of thigh/knee	7.98	NA	5.97	1.24	NA	15.19	090
27499	.....	A	Decompression of thigh/knee	8.99	NA	6.84	1.47	NA	17.30	090
27500	.....	A	Treatment of thigh fracture	5.91	6.14	5.00	1.02	13.07	11.93	090
27501	.....	A	Treatment of thigh fracture	5.91	5.81	5.40	1.03	12.75	12.34	090
27502	.....	A	Treatment of thigh fracture	10.56	NA	8.13	1.78	NA	20.47	090
27503	.....	A	Treatment of thigh fracture	10.56	NA	8.31	1.84	NA	20.71	090
27506	.....	A	Treatment of thigh fracture	17.42	NA	12.82	3.03	NA	33.27	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
27507	.....	A	Treatment of thigh fracture	13.97	NA	9.87	2.42	NA	26.26	090
27508	.....	A	Treatment of thigh fracture	5.82	6.48	5.50	0.97	13.27	12.29	090
27509	.....	A	Treatment of thigh fracture	7.70	NA	7.98	1.34	NA	17.02	090
27510	.....	A	Treatment of thigh fracture	9.12	NA	7.35	1.53	NA	18.00	090
27511	.....	A	Treatment of thigh fracture	13.62	NA	11.23	2.37	NA	27.22	090
27513	.....	A	Treatment of thigh fracture	17.89	NA	13.92	3.12	NA	34.93	090
27514	.....	A	Treatment of thigh fracture	17.27	NA	13.39	3.00	NA	33.66	090
27516	.....	A	Treat thigh fx growth plate	5.36	6.37	5.53	0.81	12.54	11.70	090
27517	.....	A	Treat thigh fx growth plate	8.77	NA	7.47	1.22	NA	17.46	090
27519	.....	A	Treat thigh fx growth plate	15.00	NA	11.62	2.55	NA	29.17	090
27520	.....	A	Treat kneecap fracture	2.86	4.55	3.45	0.47	7.88	6.78	090
27524	.....	A	Treat kneecap fracture	9.99	NA	8.25	1.74	NA	19.98	090
27530	.....	A	Treat knee fracture	3.77	5.33	4.43	0.65	9.75	8.85	090
27532	.....	A	Treat knee fracture	7.29	7.38	6.47	1.26	15.93	15.02	090
27535	.....	A	Treat knee fracture	11.48	NA	10.14	2.00	NA	23.62	090
27536	.....	A	Treat knee fracture	15.63	NA	11.64	2.73	NA	30.00	090
27538	.....	A	Treat knee fracture(s)	4.86	6.15	5.21	0.84	11.85	10.91	090
27540	.....	A	Treat knee fracture	13.08	NA	9.54	2.27	NA	24.89	090
27550	.....	A	Treat knee dislocation	5.75	6.03	4.94	0.76	12.54	11.45	090
27552	.....	A	Treat knee dislocation	7.89	NA	6.97	1.36	NA	16.22	090
27556	.....	A	Treat knee dislocation	14.39	NA	11.68	2.50	NA	28.57	090
27557	.....	A	Treat knee dislocation	16.74	NA	13.16	2.97	NA	32.87	090
27558	.....	A	Treat knee dislocation	17.69	NA	13.08	3.08	NA	33.85	090
27560	.....	A	Treat kneecap dislocation	3.81	4.85	3.19	0.40	9.06	7.40	090
27562	.....	A	Treat kneecap dislocation	5.78	NA	4.78	0.94	NA	11.50	090
27566	.....	A	Treat kneecap dislocation	12.21	NA	9.35	2.12	NA	23.68	090
27570	.....	A	Fixation of knee joint	1.74	NA	1.78	0.30	NA	3.82	010
27580	.....	A	Fusion of knee	19.34	NA	14.84	3.37	NA	37.55	090
27590	.....	A	Amputate leg at thigh	12.01	NA	6.69	1.74	NA	20.44	090
27591	.....	A	Amputate leg at thigh	12.66	NA	8.67	2.02	NA	23.35	090
27592	.....	A	Amputate leg at thigh	10.00	NA	6.19	1.45	NA	17.64	090
27594	.....	A	Amputation follow-up surgery	6.91	NA	5.18	1.02	NA	13.11	090
27596	.....	A	Amputation follow-up surgery	10.58	NA	6.83	1.57	NA	18.98	090
27598	.....	A	Amputate lower leg at knee	10.51	NA	7.04	1.65	NA	19.20	090
27599	.....	C	Leg surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
27600	.....	A	Decompression of lower leg	5.64	NA	4.54	0.86	NA	11.04	090
27601	.....	A	Decompression of lower leg	5.63	NA	4.86	0.80	NA	11.29	090
27602	.....	A	Decompression of lower leg	7.34	NA	5.14	1.10	NA	13.58	090
27603	.....	A	Drain lower leg lesion	4.93	7.51	4.17	0.74	13.18	9.84	090
27604	.....	A	Drain lower leg bursa	4.46	6.10	3.97	0.69	11.25	9.12	090
27605	.....	A	Incision of achilles tendon	2.87	7.70	2.33	0.41	10.98	5.61	010
27606	.....	A	Incision of achilles tendon	4.13	NA	3.37	0.69	NA	8.19	010
27607	.....	A	Treat lower leg bone lesion	7.96	NA	6.19	1.31	NA	15.46	090
27610	.....	A	Explore/treat ankle joint	8.33	NA	7.02	1.40	NA	16.75	090
27612	.....	A	Exploration of ankle joint	7.32	NA	6.11	1.13	NA	14.56	090
27613	.....	A	Biopsy lower leg soft tissue	2.17	3.24	1.81	0.20	5.61	4.18	010
27614	.....	A	Biopsy lower leg soft tissue	5.65	7.15	4.45	0.78	13.58	10.88	090
27615	.....	A	Remove tumor, lower leg	12.54	NA	9.42	1.83	NA	23.79	090
27618	.....	A	Remove lower leg lesion	5.08	6.03	4.00	0.72	11.83	9.80	090
27619	.....	A	Remove lower leg lesion	8.39	9.54	5.97	1.25	19.18	15.61	090
27620	.....	A	Explore/treat ankle joint	5.97	NA	5.48	0.97	NA	12.42	090
27625	.....	A	Remove ankle joint lining	8.29	NA	6.48	1.28	NA	16.05	090
27626	.....	A	Remove ankle joint lining	8.90	NA	6.94	1.48	NA	17.32	090
27630	.....	A	Removal of tendon lesion	4.79	7.58	4.39	0.74	13.11	9.92	090
27635	.....	A	Remove lower leg bone lesion	7.77	NA	6.76	1.31	NA	15.84	090
27637	.....	A	Remove/graft leg bone lesion	9.84	NA	8.31	1.66	NA	19.81	090
27638	.....	A	Remove/graft leg bone lesion	10.55	NA	8.31	1.84	NA	20.70	090
27640	.....	A	Partial removal of tibia	11.35	NA	10.34	1.88	NA	23.57	090
27641	.....	A	Partial removal of fibula	9.23	NA	8.36	1.46	NA	19.05	090
27645	.....	A	Extensive lower leg surgery	14.15	NA	12.08	2.41	NA	28.64	090
27646	.....	A	Extensive lower leg surgery	12.64	NA	11.06	2.05	NA	25.75	090
27647	.....	A	Extensive ankle/heel surgery	12.22	NA	7.63	1.75	NA	21.60	090
27648	.....	A	Injection for ankle x-ray	0.96	3.53	0.33	0.08	4.57	1.37	000
27650	.....	A	Repair achilles tendon	9.68	NA	7.53	1.59	NA	18.80	090
27652	.....	A	Repair/graft achilles tendon	10.31	NA	8.05	1.71	NA	20.07	090
27654	.....	A	Repair of achilles tendon	10.00	NA	7.16	1.58	NA	18.74	090
27656	.....	A	Repair leg fascia defect	4.56	8.55	3.78	0.69	13.80	9.03	090
27658	.....	A	Repair of leg tendon, each	4.97	NA	4.57	0.79	NA	10.33	090
27659	.....	A	Repair of leg tendon, each	6.80	NA	5.66	1.09	NA	13.55	090
27664	.....	A	Repair of leg tendon, each	4.58	NA	4.56	0.76	NA	9.90	090
27665	.....	A	Repair of leg tendon, each	5.39	NA	4.98	0.89	NA	11.26	090
27675	.....	A	Repair lower leg tendons	7.17	NA	5.75	1.11	NA	14.03	090
27676	.....	A	Repair lower leg tendons	8.41	NA	6.77	1.37	NA	16.55	090
27680	.....	A	Release of lower leg tendon	5.73	NA	5.12	0.93	NA	11.78	090
27681	.....	A	Release of lower leg tendons	6.81	NA	5.93	1.15	NA	13.89	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
27685	.....	A	Revision of lower leg tendon	6.49	7.31	5.48	0.97	14.77	12.94	090
27686	.....	A	Revise lower leg tendons	7.45	NA	6.51	1.24	NA	15.20	090
27687	.....	A	Revision of calf tendon	6.23	NA	5.33	1.00	NA	12.56	090
27690	.....	A	Revise lower leg tendon	8.70	NA	6.37	1.33	NA	16.40	090
27691	.....	A	Revise lower leg tendon	9.95	NA	7.78	1.64	NA	19.37	090
27692	.....	A	Revise additional leg tendon	1.87	NA	0.93	0.32	NA	3.12	ZZZ
27695	.....	A	Repair of ankle ligament	6.50	NA	5.89	1.05	NA	13.44	090
27696	.....	A	Repair of ankle ligaments	8.26	NA	6.45	1.28	NA	15.99	090
27698	.....	A	Repair of ankle ligament	9.35	NA	6.96	1.47	NA	17.78	090
27700	.....	A	Revision of ankle joint	9.28	NA	5.70	1.30	NA	16.28	090
27702	.....	A	Reconstruct ankle joint	13.65	NA	10.49	2.37	NA	26.51	090
27703	.....	A	Reconstruction, ankle joint	15.85	NA	11.26	2.76	NA	29.87	090
27704	.....	A	Removal of ankle implant	7.61	NA	5.61	1.27	NA	14.49	090
27705	.....	A	Incision of tibia	10.36	NA	8.19	1.80	NA	20.35	090
27707	.....	A	Incision of fibula	4.36	NA	4.95	0.76	NA	10.07	090
27709	.....	A	Incision of tibia & fibula	9.94	NA	8.15	1.73	NA	19.82	090
27712	.....	A	Realignment of lower leg	14.23	NA	10.77	2.47	NA	27.47	090
27715	.....	A	Revision of lower leg	14.37	NA	10.80	2.49	NA	27.66	090
27720	.....	A	Repair of tibia	11.77	NA	9.43	2.04	NA	23.24	090
27722	.....	A	Repair/graft of tibia	11.80	NA	9.16	2.05	NA	23.01	090
27724	.....	A	Repair/graft of tibia	18.17	NA	12.40	3.16	NA	33.73	090
27725	.....	A	Repair of lower leg	15.57	NA	11.94	2.71	NA	30.22	090
27727	.....	A	Repair of lower leg	13.99	NA	10.37	2.43	NA	26.79	090
27730	.....	A	Repair of tibia epiphysis	7.40	NA	6.44	1.72	NA	15.56	090
27732	.....	A	Repair of fibula epiphysis	5.31	NA	4.94	0.77	NA	11.02	090
27734	.....	A	Repair lower leg epiphyses	8.47	NA	6.30	1.35	NA	16.12	090
27740	.....	A	Repair of leg epiphyses	9.29	NA	8.01	1.62	NA	18.92	090
27742	.....	A	Repair of leg epiphyses	10.28	5.58	5.58	1.79	17.65	17.65	090
27745	.....	A	Reinforce tibia	10.05	NA	8.19	1.75	NA	19.99	090
27750	.....	A	Treatment of tibia fracture	3.19	4.77	3.86	0.55	8.51	7.60	090
27752	.....	A	Treatment of tibia fracture	5.83	6.67	5.69	1.01	13.51	12.53	090
27756	.....	A	Treatment of tibia fracture	6.77	NA	6.48	1.17	NA	14.42	090
27758	.....	A	Treatment of tibia fracture	11.65	NA	9.21	2.03	NA	22.89	090
27759	.....	A	Treatment of tibia fracture	13.74	NA	10.34	2.38	NA	26.46	090
27760	.....	A	Treatment of ankle fracture	3.01	4.69	3.60	0.48	8.18	7.09	090
27762	.....	A	Treatment of ankle fracture	5.24	6.35	5.29	0.85	12.44	11.38	090
27766	.....	A	Treatment of ankle fracture	8.35	NA	7.24	1.44	NA	17.03	090
27780	.....	A	Treatment of fibula fracture	2.65	4.19	3.22	0.41	7.25	6.28	090
27781	.....	A	Treatment of fibula fracture	4.39	5.51	4.65	0.73	10.63	9.77	090
27784	.....	A	Treatment of fibula fracture	7.10	NA	6.49	1.23	NA	14.82	090
27786	.....	A	Treatment of ankle fracture	2.84	4.47	3.34	0.46	7.77	6.64	090
27788	.....	A	Treatment of ankle fracture	4.44	5.66	4.66	0.74	10.84	9.84	090
27792	.....	A	Treatment of ankle fracture	7.65	NA	6.98	1.32	NA	15.95	090
27808	.....	A	Treatment of ankle fracture	2.83	4.81	3.71	0.46	8.10	7.00	090
27810	.....	A	Treatment of ankle fracture	5.12	6.26	5.16	0.82	12.20	11.10	090
27814	.....	A	Treatment of ankle fracture	10.66	NA	8.58	1.85	NA	21.09	090
27816	.....	A	Treatment of ankle fracture	2.89	4.39	3.42	0.43	7.71	6.74	090
27818	.....	A	Treatment of ankle fracture	5.49	6.39	5.18	0.82	12.70	11.49	090
27822	.....	A	Treatment of ankle fracture	10.98	NA	10.68	1.91	NA	23.57	090
27823	.....	A	Treatment of ankle fracture	12.98	NA	11.50	2.25	NA	26.73	090
27824	.....	A	Treat lower leg fracture	2.89	4.07	3.57	0.45	7.41	6.91	090
27825	.....	A	Treat lower leg fracture	6.18	6.62	5.40	1.02	13.82	12.60	090
27826	.....	A	Treat lower leg fracture	8.53	NA	8.85	1.47	NA	18.85	090
27827	.....	A	Treat lower leg fracture	14.04	NA	12.80	2.43	NA	29.27	090
27828	.....	A	Treat lower leg fracture	16.21	NA	13.97	2.81	NA	32.99	090
27829	.....	A	Treat lower leg joint	5.48	NA	6.80	0.95	NA	13.23	090
27830	.....	A	Treat lower leg dislocation	3.78	4.40	3.86	0.54	8.72	8.18	090
27831	.....	A	Treat lower leg dislocation	4.55	NA	4.47	0.73	NA	9.75	090
27832	.....	A	Treat lower leg dislocation	6.48	NA	6.19	1.03	NA	13.70	090
27840	.....	A	Treat ankle dislocation	4.57	NA	3.77	0.46	NA	8.80	090
27842	.....	A	Treat ankle dislocation	6.20	NA	5.13	1.00	NA	12.33	090
27846	.....	A	Treat ankle dislocation	9.78	NA	7.95	1.70	NA	19.43	090
27848	.....	A	Treat ankle dislocation	11.18	NA	9.74	1.94	NA	22.86	090
27860	.....	A	Fixation of ankle joint	2.34	NA	1.99	0.39	NA	4.72	010
27870	.....	A	Fusion of ankle joint, open	13.89	NA	10.55	2.36	NA	26.80	090
27871	.....	A	Fusion of tibiofibular joint	9.16	NA	7.60	1.59	NA	18.35	090
27880	.....	A	Amputation of lower leg	11.83	NA	7.15	1.75	NA	20.73	090
27881	.....	A	Amputation of lower leg	12.32	NA	8.87	1.98	NA	23.17	090
27882	.....	A	Amputation of lower leg	8.93	NA	6.50	1.29	NA	16.72	090
27884	.....	A	Amputation follow-up surgery	8.20	NA	5.77	1.22	NA	15.19	090
27886	.....	A	Amputation follow-up surgery	9.31	NA	6.53	1.40	NA	17.24	090
27888	.....	A	Amputation of foot at ankle	9.66	NA	7.52	1.51	NA	18.69	090
27889	.....	A	Amputation of foot at ankle	9.97	NA	6.49	1.46	NA	17.92	090
27892	.....	A	Decompression of leg	7.38	NA	5.61	1.10	NA	14.09	090
27893	.....	A	Decompression of leg	7.34	NA	5.48	1.10	NA	13.92	090

[3] +Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
27894	.....	A	Decompression of leg	10.47	NA	7.79	1.65	NA	19.91	090
27899	.....	C	Leg/ankle surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
28001	.....	A	Drainage of bursa of foot	2.73	2.99	1.96	0.33	6.05	5.02	010
28002	.....	A	Treatment of foot infection	4.61	5.00	3.78	0.61	10.22	9.00	010
28003	.....	A	Treatment of foot infection	8.40	6.25	5.24	1.12	15.77	14.76	090
28005	.....	A	Treat foot bone lesion	8.67	NA	6.06	1.16	NA	15.89	090
28008	.....	A	Incision of foot fascia	4.44	4.56	3.21	0.57	9.57	8.22	090
28010	.....	A	Incision of toe tendon	2.84	2.38	2.38	0.36	5.58	5.58	090
28011	.....	A	Incision of toe tendons	4.13	NA	3.31	0.59	NA	8.03	090
28020	.....	A	Exploration of foot joint	5.00	6.03	4.14	0.72	11.75	9.86	090
28022	.....	A	Exploration of foot joint	4.66	5.21	3.86	0.62	10.49	9.14	090
28024	.....	A	Exploration of toe joint	4.37	5.23	3.93	0.58	10.18	8.88	090
28030	.....	A	Removal of foot nerve	6.14	NA	3.66	0.74	NA	10.54	090
28035	.....	A	Decompression of tibia nerve	5.08	5.87	4.10	0.70	11.65	9.88	090
28043	.....	A	Excision of foot lesion	3.53	3.82	3.18	0.46	7.81	7.17	090
28045	.....	A	Excision of foot lesion	4.71	5.39	3.61	0.63	10.73	8.95	090
28046	.....	A	Resection of tumor, foot	10.16	8.79	6.49	1.36	20.31	18.01	090
28050	.....	A	Biopsy of foot joint lining	4.24	4.90	3.60	0.60	9.74	8.44	090
28052	.....	A	Biopsy of foot joint lining	3.93	4.92	3.44	0.53	9.38	7.90	090
28054	.....	A	Biopsy of toe joint lining	3.44	4.73	3.24	0.46	8.63	7.14	090
28060	.....	A	Partial removal, foot fascia	5.22	5.49	3.88	0.70	11.41	9.80	090
28062	.....	A	Removal of foot fascia	6.51	6.53	4.02	0.83	13.87	11.36	090
28070	.....	A	Removal of foot joint lining	5.09	5.23	3.82	0.73	11.05	9.64	090
28072	.....	A	Removal of foot joint lining	4.57	5.54	4.31	0.68	10.79	9.56	090
28080	.....	A	Removal of foot lesion	3.57	5.12	3.69	0.47	9.16	7.73	090
28086	.....	A	Excise foot tendon sheath	4.77	8.00	4.69	0.76	13.53	10.22	090
28088	.....	A	Excise foot tendon sheath	3.85	5.77	3.90	0.61	10.23	8.36	090
28090	.....	A	Removal of foot lesion	4.40	5.15	3.46	0.59	10.14	8.45	090
28092	.....	A	Removal of toe lesions	3.63	5.23	3.53	0.49	9.35	7.65	090
28100	.....	A	Removal of ankle/heel lesion	5.65	7.98	4.70	0.82	14.45	11.17	090
28102	.....	A	Remove/graft foot lesion	7.72	NA	5.96	1.14	NA	14.82	090
28103	.....	A	Remove/graft foot lesion	6.49	NA	4.62	0.91	NA	12.02	090
28104	.....	A	Removal of foot lesion	5.11	5.50	3.93	0.70	11.31	9.74	090
28106	.....	A	Remove/graft foot lesion	7.15	NA	4.44	0.97	NA	12.56	090
28107	.....	A	Remove/graft foot lesion	5.55	6.54	4.21	0.74	12.83	10.50	090
28108	.....	A	Removal of toe lesions	4.15	4.60	3.26	0.53	9.28	7.94	090
28110	.....	A	Part removal of metatarsal	4.07	5.23	3.23	0.54	9.84	7.84	090
28111	.....	A	Part removal of metatarsal	5.00	6.29	3.66	0.67	11.96	9.33	090
28112	.....	A	Part removal of metatarsal	4.48	5.82	3.58	0.61	10.91	8.67	090
28113	.....	A	Part removal of metatarsal	4.78	6.07	4.32	0.63	11.48	9.73	090
28114	.....	A	Removal of metatarsal heads	9.78	11.65	8.39	1.42	22.85	19.59	090
28116	.....	A	Revision of foot	7.74	6.81	5.18	1.03	15.58	13.95	090
28118	.....	A	Removal of heel bone	5.95	6.26	4.35	0.84	13.05	11.14	090
28119	.....	A	Removal of heel spur	5.38	5.44	3.73	0.70	11.52	9.81	090
28120	.....	A	Part removal of ankle/heel	5.39	7.30	4.42	0.77	13.46	10.58	090
28122	.....	A	Partial removal of foot bone	7.28	6.85	5.28	0.98	15.11	13.54	090
28124	.....	A	Partial removal of toe	4.80	5.00	3.66	0.60	10.40	9.06	090
28126	.....	A	Partial removal of toe	3.51	4.22	3.00	0.45	8.18	6.96	090
28130	.....	A	Removal of ankle bone	8.10	NA	6.73	1.26	NA	16.09	090
28140	.....	A	Removal of metatarsal	6.90	7.24	4.77	0.92	15.06	12.59	090
28150	.....	A	Removal of toe	4.08	4.84	3.29	0.53	9.45	7.90	090
28153	.....	A	Partial removal of toe	3.65	4.32	2.69	0.47	8.44	6.81	090
28160	.....	A	Partial removal of toe	3.73	4.57	3.34	0.49	8.79	7.56	090
28171	.....	A	Extensive foot surgery	9.59	NA	5.44	1.33	NA	16.36	090
28173	.....	A	Extensive foot surgery	8.79	7.61	5.21	1.12	17.52	15.12	090
28175	.....	A	Extensive foot surgery	6.04	5.72	3.71	0.73	12.49	10.48	090
28190	.....	A	Removal of foot foreign body	1.96	3.40	1.48	0.22	5.58	3.66	010
28192	.....	A	Removal of foot foreign body	4.63	5.49	3.65	0.61	10.73	8.89	090
28193	.....	A	Removal of foot foreign body	5.72	5.62	3.93	0.73	12.07	10.38	090
28200	.....	A	Repair of foot tendon	4.59	5.10	3.56	0.61	10.30	8.76	090
28202	.....	A	Repair/graft of foot tendon	6.83	7.23	4.50	0.91	14.97	12.24	090
28208	.....	A	Repair of foot tendon	4.36	4.82	3.31	0.58	9.76	8.25	090
28210	.....	A	Repair/graft of foot tendon	6.34	6.23	4.03	0.81	13.38	11.18	090
28220	.....	A	Release of foot tendon	4.52	4.68	3.43	0.57	9.77	8.52	090
28222	.....	A	Release of foot tendons	5.61	5.25	4.13	0.69	11.55	10.43	090
28225	.....	A	Release of foot tendon	3.65	4.29	2.91	0.46	8.40	7.02	090
28226	.....	A	Release of foot tendons	4.52	4.80	3.75	0.58	9.90	8.85	090
28230	.....	A	Incision of foot tendon(s)	4.23	4.68	3.68	0.55	9.46	8.46	090
28232	.....	A	Incision of toe tendon	3.38	4.53	3.32	0.44	8.35	7.14	090
28234	.....	A	Incision of foot tendon	3.36	4.68	3.36	0.44	8.48	7.16	090
28238	.....	A	Revision of foot tendon	7.72	7.26	4.94	1.06	16.04	13.72	090
28240	.....	A	Release of big toe	4.35	4.64	3.49	0.58	9.57	8.42	090
28250	.....	A	Revision of foot fascia	5.91	5.64	4.14	0.82	12.37	10.87	090
28260	.....	A	Release of midfoot joint	7.95	6.34	5.00	1.14	15.43	14.09	090
28261	.....	A	Revision of foot tendon	11.71	8.63	7.32	1.57	21.91	20.60	090

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[3] +Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
28262	.....	A	Revision of foot and ankle	15.81	13.59	10.94	2.59	31.99	29.34	090
28264	.....	A	Release of midfoot joint	10.33	7.75	7.30	1.54	19.62	19.17	090
28270	.....	A	Release of foot contracture	4.75	4.90	3.74	0.62	10.27	9.11	090
28272	.....	A	Release of toe joint, each	3.79	4.19	2.86	0.46	8.44	7.11	090
28280	.....	A	Fusion of toes	5.18	6.26	4.49	0.73	12.17	10.40	090
28285	.....	A	Repair of hammertoe	4.58	4.87	3.43	0.59	10.04	8.60	090
28286	.....	A	Repair of hammertoe	4.55	4.80	3.26	0.57	9.92	8.38	090
28288	.....	A	Partial removal of foot bone	4.73	5.95	4.89	0.65	11.33	10.27	090
28289	.....	A	Repair hallux rigidus	7.03	8.00	5.78	1.02	16.05	13.83	090
28290	.....	A	Correction of bunion	5.65	6.27	4.73	0.82	12.74	11.20	090
28292	.....	A	Correction of bunion	7.03	7.48	5.55	0.91	15.42	13.49	090
28293	.....	A	Correction of bunion	9.14	10.77	6.12	1.13	21.04	16.39	090
28294	.....	A	Correction of bunion	8.55	7.45	4.72	1.09	17.09	14.36	090
28296	.....	A	Correction of bunion	9.17	8.17	5.43	1.19	18.53	15.79	090
28297	.....	A	Correction of bunion	9.17	8.97	6.27	1.32	19.46	16.76	090
28298	.....	A	Correction of bunion	7.93	7.23	5.01	1.05	16.21	13.99	090
28299	.....	A	Correction of bunion	10.56	8.79	6.08	1.37	20.72	18.01	090
28300	.....	A	Incision of heel bone	9.53	NA	7.05	1.54	NA	18.12	090
28302	.....	A	Incision of ankle bone	9.54	NA	6.90	1.42	NA	17.86	090
28304	.....	A	Incision of midfoot bones	9.15	7.96	5.75	1.27	18.38	16.17	090
28305	.....	A	Incise/graft midfoot bones	10.48	NA	6.74	1.27	NA	18.49	090
28306	.....	A	Incision of metatarsal	5.85	6.85	4.18	0.84	13.54	10.87	090
28307	.....	A	Incision of metatarsal	6.32	11.05	5.30	0.90	18.27	12.52	090
28308	.....	A	Incision of metatarsal	5.28	5.76	3.69	0.70	11.74	9.67	090
28309	.....	A	Incision of metatarsals	12.76	NA	7.97	2.04	NA	22.77	090
28310	.....	A	Revision of big toe	5.42	5.76	3.56	0.70	11.88	9.68	090
28312	.....	A	Revision of toe	4.54	5.45	3.64	0.63	10.62	8.81	090
28313	.....	A	Repair deformity of toe	5.00	5.29	4.84	0.73	11.02	10.57	090
28315	.....	A	Removal of sesamoid bone	4.85	4.90	3.34	0.63	10.38	8.82	090
28320	.....	A	Repair of foot bones	9.17	NA	6.73	1.43	NA	17.33	090
28322	.....	A	Repair of metatarsals	8.33	9.20	6.35	1.27	18.80	15.95	090
28340	.....	A	Resect enlarged toe tissue	6.97	6.46	4.25	0.84	14.27	12.06	090
28341	.....	A	Resect enlarged toe	8.40	6.95	4.82	1.01	16.36	14.23	090
28344	.....	A	Repair extra toe(s)	4.25	5.76	3.64	0.51	10.52	8.40	090
28345	.....	A	Repair webbed toe(s)	5.91	6.21	4.69	0.80	12.92	11.40	090
28360	.....	A	Reconstruct cleft foot	13.32	NA	10.52	2.28	NA	26.12	090
28400	.....	A	Treatment of heel fracture	2.16	3.64	3.06	0.35	6.15	5.57	090
28405	.....	A	Treatment of heel fracture	4.56	4.84	4.63	0.73	10.13	9.92	090
28406	.....	A	Treatment of heel fracture	6.30	NA	6.81	1.11	NA	14.22	090
28415	.....	A	Treat heel fracture	15.95	NA	13.32	2.66	NA	31.93	090
28420	.....	A	Treat/graft heel fracture	16.62	NA	12.95	2.80	NA	32.37	090
28430	.....	A	Treatment of ankle fracture	2.09	3.40	2.57	0.31	5.80	4.97	090
28435	.....	A	Treatment of ankle fracture	3.39	3.89	3.75	0.55	7.83	7.69	090
28436	.....	A	Treatment of ankle fracture	4.70	NA	5.93	0.81	NA	11.44	090
28445	.....	A	Treat ankle fracture	15.60	NA	11.06	2.58	NA	29.24	090
28450	.....	A	Treat midfoot fracture, each	1.90	3.12	2.48	0.28	5.30	4.66	090
28455	.....	A	Treat midfoot fracture, each	3.09	3.43	3.43	0.44	6.96	6.96	090
28456	.....	A	Treat midfoot fracture	2.68	NA	4.16	0.44	NA	7.28	090
28465	.....	A	Treat midfoot fracture, each	7.00	NA	6.33	1.10	NA	14.43	090
28470	.....	A	Treat metatarsal fracture	1.99	3.13	2.45	0.30	5.42	4.74	090
28475	.....	A	Treat metatarsal fracture	2.97	3.34	3.22	0.44	6.75	6.63	090
28476	.....	A	Treat metatarsal fracture	3.37	NA	4.99	0.54	NA	8.90	090
28485	.....	A	Treat metatarsal fracture	5.70	NA	5.46	0.83	NA	11.99	090
28490	.....	A	Treat big toe fracture	1.09	2.02	1.64	0.14	3.25	2.87	090
28495	.....	A	Treat big toe fracture	1.58	2.18	2.07	0.20	3.96	3.85	090
28496	.....	A	Treat big toe fracture	2.33	8.27	3.20	0.36	10.96	5.89	090
28505	.....	A	Treat big toe fracture	3.80	8.12	3.91	0.56	12.48	8.27	090
28510	.....	A	Treatment of toe fracture	1.09	1.53	1.53	0.14	2.76	2.76	090
28515	.....	A	Treatment of toe fracture	1.46	1.90	1.90	0.18	3.54	3.54	090
28525	.....	A	Treat toe fracture	3.32	7.53	3.44	0.49	11.34	7.25	090
28530	.....	A	Treat sesamoid bone fracture	1.06	1.44	1.44	0.14	2.64	2.64	090
28531	.....	A	Treat sesamoid bone fracture	2.35	7.28	2.07	0.34	9.97	4.76	090
28540	.....	A	Treat foot dislocation	2.04	2.41	2.41	0.26	4.71	4.71	090
28545	.....	A	Treat foot dislocation	2.45	2.35	2.35	0.37	5.17	5.17	090
28546	.....	A	Treat foot dislocation	3.20	6.93	4.39	0.52	10.65	8.11	090
28555	.....	A	Repair foot dislocation	6.29	9.93	5.69	1.04	17.26	13.02	090
28570	.....	A	Treat foot dislocation	1.66	2.43	2.34	0.23	4.32	4.23	090
28575	.....	A	Treat foot dislocation	3.31	3.73	3.73	0.56	7.60	7.60	090
28576	.....	A	Treat foot dislocation	4.16	NA	4.18	0.69	NA	9.03	090
28585	.....	A	Repair foot dislocation	7.98	7.34	5.85	1.25	16.57	15.08	090
28600	.....	A	Treat foot dislocation	1.89	2.82	2.69	0.27	4.98	4.85	090
28605	.....	A	Treat foot dislocation	2.71	3.13	3.13	0.40	6.24	6.24	090
28606	.....	A	Treat foot dislocation	4.89	NA	4.70	0.82	NA	10.41	090
28615	.....	A	Repair foot dislocation	7.76	NA	8.06	1.30	NA	17.12	090
28630	.....	A	Treat toe dislocation	1.70	1.57	1.00	0.20	3.47	2.90	010

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
28635	.....	A	Treat toe dislocation	1.91	2.03	1.53	0.26	4.20	3.70	010
28636	.....	A	Treat toe dislocation	2.77	3.88	2.63	0.43	7.08	5.83	010
28645	.....	A	Repair toe dislocation	4.21	4.96	3.28	0.57	9.74	8.06	090
28660	.....	A	Treat toe dislocation	1.23	1.26	0.79	0.13	2.62	2.15	010
28665	.....	A	Treat toe dislocation	1.92	NA	1.43	0.26	NA	3.61	010
28666	.....	A	Treat toe dislocation	2.66	5.90	2.59	0.43	8.99	5.68	010
28675	.....	A	Repair of toe dislocation	2.92	7.16	3.36	0.45	10.53	6.73	090
28705	.....	A	Fusion of foot bones	18.77	NA	12.47	3.08	NA	34.32	090
28715	.....	A	Fusion of foot bones	13.08	NA	9.78	2.16	NA	25.02	090
28725	.....	A	Fusion of foot bones	11.59	NA	8.26	1.86	NA	21.71	090
28730	.....	A	Fusion of foot bones	10.74	NA	8.50	1.70	NA	20.94	090
28735	.....	A	Fusion of foot bones	10.83	NA	7.84	1.68	NA	20.35	090
28737	.....	A	Revision of foot bones	9.63	NA	6.82	1.47	NA	17.92	090
28740	.....	A	Fusion of foot bones	8.01	10.89	6.48	1.22	20.12	15.71	090
28750	.....	A	Fusion of big toe joint	7.29	11.94	6.68	1.13	20.36	15.10	090
28755	.....	A	Fusion of big toe joint	4.73	6.12	3.76	0.65	11.50	9.14	090
28760	.....	A	Fusion of big toe joint	7.74	7.99	5.53	1.05	16.78	14.32	090
28800	.....	A	Amputation of midfoot	8.20	NA	5.81	1.15	NA	15.16	090
28805	.....	A	Amputation thru metatarsal	8.38	NA	5.66	1.18	NA	15.22	090
28810	.....	A	Amputation toe & metatarsal	6.20	NA	4.48	0.86	NA	11.54	090
28820	.....	A	Amputation of toe	4.40	7.57	3.79	0.61	12.58	8.80	090
28825	.....	A	Partial amputation of toe	3.58	7.01	3.49	0.50	11.09	7.57	090
28890	.....	A	High energy eswt, plantar f	3.30	5.73	2.09	0.41	9.44	5.80	090
28899	.....	C	Foot/toes surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
29000	.....	A	Application of body cast	2.25	2.97	1.74	0.41	5.63	4.40	000
29010	.....	A	Application of body cast	2.06	3.29	1.78	0.45	5.80	4.29	000
29015	.....	A	Application of body cast	2.41	2.98	1.60	0.28	5.67	4.29	000
29020	.....	A	Application of body cast	2.11	3.19	1.41	0.28	5.58	3.80	000
29025	.....	A	Application of body cast	2.40	3.15	1.86	0.44	5.99	4.70	000
29035	.....	A	Application of body cast	1.77	3.62	1.58	0.28	5.67	3.63	000
29040	.....	A	Application of body cast	2.22	2.47	1.51	0.36	5.05	4.09	000
29044	.....	A	Application of body cast	2.12	3.98	1.91	0.35	6.45	4.38	000
29046	.....	A	Application of body cast	2.41	3.24	2.10	0.42	6.07	4.93	000
29049	.....	A	Application of figure eight	0.89	1.30	0.53	0.13	2.32	1.55	000
29055	.....	A	Application of shoulder cast	1.78	2.99	1.47	0.30	5.07	3.55	000
29058	.....	A	Application of shoulder cast	1.31	1.56	0.72	0.17	3.04	2.20	000
29065	.....	A	Application of long arm cast	0.87	1.33	0.75	0.15	2.35	1.77	000
29075	.....	A	Application of forearm cast	0.77	1.26	0.68	0.13	2.16	1.58	000
29085	.....	A	Apply hand/wrist cast	0.87	1.28	0.63	0.14	2.29	1.64	000
29086	.....	A	Apply finger cast	0.62	0.96	0.49	0.07	1.65	1.18	000
29105	.....	A	Apply long arm splint	0.87	1.23	0.51	0.12	2.22	1.50	000
29125	.....	A	Apply forearm splint	0.59	1.02	0.39	0.07	1.68	1.05	000
29126	.....	A	Apply forearm splint	0.77	1.21	0.46	0.07	2.05	1.30	000
29130	.....	A	Application of finger splint	0.50	0.47	0.17	0.06	1.03	0.73	000
29131	.....	A	Application of finger splint	0.55	0.74	0.24	0.03	1.32	0.82	000
29200	.....	A	Strapping of chest	0.65	0.72	0.34	0.04	1.41	1.03	000
29220	.....	A	Strapping of low back	0.64	0.72	0.39	0.04	1.40	1.07	000
29240	.....	A	Strapping of shoulder	0.71	0.85	0.36	0.06	1.62	1.13	000
29260	.....	A	Strapping of elbow or wrist	0.55	0.74	0.32	0.05	1.34	0.92	000
29280	.....	A	Strapping of hand or finger	0.51	0.80	0.32	0.03	1.34	0.86	000
29305	.....	A	Application of hip cast	2.03	3.35	1.77	0.35	5.73	4.15	000
29325	.....	A	Application of hip casts	2.32	3.54	1.96	0.40	6.26	4.68	000
29345	.....	A	Application of long leg cast	1.40	1.77	1.06	0.24	3.41	2.70	000
29355	.....	A	Application of long leg cast	1.53	1.71	1.12	0.26	3.50	2.91	000
29358	.....	A	Apply long leg cast brace	1.43	2.07	1.09	0.25	3.75	2.77	000
29365	.....	A	Application of long leg cast	1.18	1.66	0.95	0.20	3.04	2.33	000
29405	.....	A	Apply short leg cast	0.86	1.22	0.71	0.14	2.22	1.71	000
29425	.....	A	Apply short leg cast	1.01	1.23	0.74	0.15	2.39	1.90	000
29435	.....	A	Apply short leg cast	1.18	1.56	0.93	0.20	2.94	2.31	000
29440	.....	A	Addition of walker to cast	0.57	0.69	0.27	0.08	1.34	0.92	000
29445	.....	A	Apply rigid leg cast	1.78	1.81	0.96	0.27	3.86	3.01	000
29450	.....	A	Application of leg cast	2.08	1.47	1.09	0.27	3.82	3.44	000
29505	.....	A	Application, long leg splint	0.69	1.18	0.45	0.08	1.95	1.22	000
29515	.....	A	Application lower leg splint	0.73	0.87	0.46	0.09	1.69	1.28	000
29520	.....	A	Strapping of hip	0.54	0.85	0.47	0.03	1.42	1.04	000
29530	.....	A	Strapping of knee	0.57	0.79	0.33	0.05	1.41	0.95	000
29540	.....	A	Strapping of ankle and/or ft	0.51	0.42	0.31	0.06	0.99	0.88	000
29550	.....	A	Strapping of toes	0.47	0.42	0.28	0.06	0.95	0.81	000
29580	.....	A	Application of paste boot	0.57	0.65	0.35	0.07	1.29	0.99	000
29590	.....	A	Application of foot splint	0.76	0.51	0.29	0.09	1.36	1.14	000
29700	.....	A	Removal/revision of cast	0.57	0.89	0.28	0.08	1.54	0.93	000
29705	.....	A	Removal/revision of cast	0.76	0.82	0.38	0.13	1.71	1.27	000
29710	.....	A	Removal/revision of cast	1.34	1.53	0.70	0.20	3.07	2.24	000
29715	.....	A	Removal/revision of cast	0.94	1.17	0.40	0.09	2.20	1.43	000
29720	.....	A	Repair of body cast	0.68	1.16	0.39	0.12	1.96	1.19	000

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
29730	.....	A	Windowing of cast	0.75	0.81	0.35	0.12	1.68	1.22	000
29740	.....	A	Wedging of cast	1.12	1.15	0.49	0.18	2.45	1.79	000
29750	.....	A	Wedging of clubfoot cast	1.26	1.06	0.58	0.21	2.53	2.05	000
29799	.....	C	Casting/strapping procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
29800	.....	A	Jaw arthroscopy/surgery	6.42	NA	6.99	0.99	NA	14.40	090
29804	.....	A	Jaw arthroscopy/surgery	8.13	NA	7.64	1.38	NA	17.15	090
29805	.....	A	Shoulder arthroscopy, dx	5.88	NA	5.69	1.02	NA	12.59	090
29806	.....	A	Shoulder arthroscopy/surgery	14.35	NA	11.19	2.49	NA	28.03	090
29807	.....	A	Shoulder arthroscopy/surgery	13.88	NA	11.02	2.41	NA	27.31	090
29819	.....	A	Shoulder arthroscopy/surgery	7.61	NA	6.81	1.32	NA	15.74	090
29820	.....	A	Shoulder arthroscopy/surgery	7.06	NA	6.24	1.22	NA	14.52	090
29821	.....	A	Shoulder arthroscopy/surgery	7.71	NA	6.82	1.33	NA	15.86	090
29822	.....	A	Shoulder arthroscopy/surgery	7.42	NA	6.71	1.28	NA	15.41	090
29823	.....	A	Shoulder arthroscopy/surgery	8.16	NA	7.24	1.41	NA	16.81	090
29824	.....	A	Shoulder arthroscopy/surgery	8.24	NA	7.55	1.42	NA	17.21	090
29825	.....	A	Shoulder arthroscopy/surgery	7.61	NA	6.78	1.32	NA	15.71	090
29826	.....	A	Shoulder arthroscopy/surgery	8.98	NA	7.55	1.55	NA	18.08	090
29827	.....	A	Arthroscop rotator cuff repr	15.34	NA	11.56	2.66	NA	29.56	090
29830	.....	A	Elbow arthroscopy	5.75	NA	5.36	0.99	NA	12.10	090
29834	.....	A	Elbow arthroscopy/surgery	6.27	NA	5.85	1.08	NA	13.20	090
29835	.....	A	Elbow arthroscopy/surgery	6.47	NA	5.90	1.13	NA	13.50	090
29836	.....	A	Elbow arthroscopy/surgery	7.54	NA	6.81	1.22	NA	15.57	090
29837	.....	A	Elbow arthroscopy/surgery	6.86	NA	6.15	1.19	NA	14.20	090
29838	.....	A	Elbow arthroscopy/surgery	7.70	NA	6.91	1.30	NA	15.91	090
29840	.....	A	Wrist arthroscopy	5.53	NA	5.34	0.84	NA	11.71	090
29843	.....	A	Wrist arthroscopy/surgery	6.00	NA	5.64	0.92	NA	12.56	090
29844	.....	A	Wrist arthroscopy/surgery	6.36	NA	5.84	1.04	NA	13.24	090
29845	.....	A	Wrist arthroscopy/surgery	7.51	NA	6.49	0.99	NA	14.99	090
29846	.....	A	Wrist arthroscopy/surgery	6.74	NA	6.07	1.07	NA	13.88	090
29847	.....	A	Wrist arthroscopy/surgery	7.07	NA	6.21	1.08	NA	14.36	090
29848	.....	A	Wrist endoscopy/surgery	5.43	NA	5.62	0.86	NA	11.91	090
29850	.....	A	Knee arthroscopy/surgery	8.18	NA	5.05	1.25	NA	14.48	090
29851	.....	A	Knee arthroscopy/surgery	13.08	NA	9.82	2.34	NA	25.24	090
29855	.....	A	Tibial arthroscopy/surgery	10.60	NA	8.79	1.84	NA	21.23	090
29856	.....	A	Tibial arthroscopy/surgery	14.12	NA	10.70	2.39	NA	27.21	090
29860	.....	A	Hip arthroscopy, dx	8.04	NA	6.97	1.36	NA	16.37	090
29861	.....	A	Hip arthroscopy/surgery	9.14	NA	7.36	1.59	NA	18.09	090
29862	.....	A	Hip arthroscopy/surgery	9.89	NA	8.58	1.62	NA	20.09	090
29863	.....	A	Hip arthroscopy/surgery	9.89	NA	8.53	1.42	NA	19.84	090
29866	.....	A	Autgrft implnt, knee w/scope	13.88	NA	11.38	2.39	NA	27.65	090
29867	.....	A	Allgrft implnt, knee w/scope	17.00	NA	13.26	2.78	NA	33.04	090
29868	.....	A	Meniscal trnspl, knee w/scpe	23.59	NA	16.84	4.35	NA	44.78	090
29870	.....	A	Knee arthroscopy, dx	5.06	NA	4.90	0.85	NA	10.81	090
29871	.....	A	Knee arthroscopy/drainage	6.54	NA	5.89	1.14	NA	13.57	090
29873	.....	A	Knee arthroscopy/surgery	5.99	NA	6.59	1.04	NA	13.62	090
29874	.....	A	Knee arthroscopy/surgery	7.04	NA	6.09	1.11	NA	14.24	090
29875	.....	A	Knee arthroscopy/surgery	6.30	NA	5.87	1.09	NA	13.26	090
29876	.....	A	Knee arthroscopy/surgery	7.91	NA	7.04	1.37	NA	16.32	090
29877	.....	A	Knee arthroscopy/surgery	7.34	NA	6.76	1.28	NA	15.38	090
29879	.....	A	Knee arthroscopy/surgery	8.03	NA	7.14	1.39	NA	16.56	090
29880	.....	A	Knee arthroscopy/surgery	8.49	NA	7.38	1.47	NA	17.34	090
29881	.....	A	Knee arthroscopy/surgery	7.75	NA	6.98	1.34	NA	16.07	090
29882	.....	A	Knee arthroscopy/surgery	8.64	NA	7.26	1.50	NA	17.40	090
29883	.....	A	Knee arthroscopy/surgery	11.03	NA	9.09	1.92	NA	22.04	090
29884	.....	A	Knee arthroscopy/surgery	7.32	NA	6.72	1.27	NA	15.31	090
29885	.....	A	Knee arthroscopy/surgery	9.08	NA	7.99	1.58	NA	18.65	090
29886	.....	A	Knee arthroscopy/surgery	7.53	NA	6.87	1.30	NA	15.70	090
29887	.....	A	Knee arthroscopy/surgery	9.03	NA	7.95	1.57	NA	18.55	090
29888	.....	A	Knee arthroscopy/surgery	13.88	NA	10.23	2.41	NA	26.52	090
29889	.....	A	Knee arthroscopy/surgery	15.98	NA	12.47	2.78	NA	31.23	090
29891	.....	A	Ankle arthroscopy/surgery	8.39	NA	7.53	1.39	NA	17.31	090
29892	.....	A	Ankle arthroscopy/surgery	8.99	NA	7.76	1.41	NA	18.16	090
29893	.....	A	Scope, plantar fasciotomy	5.21	6.30	4.00	0.63	12.14	9.84	090
29894	.....	A	Ankle arthroscopy/surgery	7.20	NA	5.49	1.15	NA	13.84	090
29895	.....	A	Ankle arthroscopy/surgery	6.98	NA	5.49	1.11	NA	13.58	090
29897	.....	A	Ankle arthroscopy/surgery	7.17	NA	5.90	1.17	NA	14.24	090
29898	.....	A	Ankle arthroscopy/surgery	8.31	NA	6.21	1.28	NA	15.80	090
29899	.....	A	Ankle arthroscopy/surgery	13.89	NA	10.57	2.40	NA	26.86	090
29900	.....	A	Mcp joint arthroscopy, dx	5.41	NA	5.88	0.94	NA	12.23	090
29901	.....	A	Mcp joint arthroscopy, surg	6.12	NA	6.28	1.06	NA	13.46	090
29902	.....	A	Mcp joint arthroscopy, surg	6.69	NA	6.56	1.12	NA	14.37	090
29999	.....	C	Arthroscopy of joint	0.00	0.00	0.00	0.00	0.00	0.00	YYY
30000	.....	A	Drainage of nose lesion	1.43	4.08	1.39	0.12	5.63	2.94	010
3000F	.....	I	Blood press </= 140/90 mmhg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
30020	.....	A	Drainage of nose lesion	1.43	3.28	1.47	0.12	4.83	3.02	010

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
3002F		I	Blood pressure > 140/90 mmhg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
30100		A	Intranasal biopsy	0.94	1.98	0.82	0.07	2.99	1.83	000
30110		A	Removal of nose polyp(s)	1.63	3.25	1.57	0.14	5.02	3.34	010
30115		A	Removal of nose polyp(s)	4.34	NA	5.78	0.41	NA	10.53	090
30117		A	Removal of intranasal lesion	3.16	13.18	4.64	0.26	16.60	8.06	090
30118		A	Removal of intranasal lesion	9.68	NA	9.22	0.78	NA	19.68	090
30120		A	Revision of nose	5.26	6.51	6.02	0.52	12.29	11.80	090
30124		A	Removal of nose lesion	3.10	NA	3.62	0.25	NA	6.97	090
30125		A	Removal of nose lesion	7.15	NA	8.34	0.63	NA	16.12	090
30130		A	Excise inferior turbinate	3.37	NA	5.61	0.31	NA	9.29	090
30140		A	Resect inferior turbinate	3.42	NA	6.21	0.35	NA	9.98	090
30150		A	Partial removal of nose	9.13	NA	11.04	0.93	NA	21.10	090
30160		A	Removal of nose	9.57	NA	10.24	0.88	NA	20.69	090
30200		A	Injection treatment of nose	0.78	1.62	0.74	0.06	2.46	1.58	000
30210		A	Nasal sinus therapy	1.08	2.11	1.31	0.09	3.28	2.48	010
30220		A	Insert nasal septal button	1.54	4.24	1.53	0.12	5.90	3.19	010
30300		A	Remove nasal foreign body	1.04	4.64	1.92	0.08	5.76	3.04	010
30310		A	Remove nasal foreign body	1.96	NA	3.11	0.16	NA	5.23	010
30320		A	Remove nasal foreign body	4.51	NA	7.06	0.39	NA	11.96	090
30400		R	Reconstruction of nose	9.82	NA	15.53	1.04	NA	26.39	090
30410		R	Reconstruction of nose	12.96	NA	18.42	1.42	NA	32.80	090
30420		R	Reconstruction of nose	15.86	NA	17.96	1.46	NA	35.28	090
30430		R	Revision of nose	7.20	NA	16.06	0.77	NA	24.03	090
30435		R	Revision of nose	11.69	NA	19.41	1.22	NA	32.32	090
30450		R	Revision of nose	18.62	NA	21.95	1.96	NA	42.53	090
30460		A	Revision of nose	9.95	NA	9.97	1.03	NA	20.95	090
30462		A	Revision of nose	19.54	NA	20.30	2.53	NA	42.37	090
30465		A	Repair nasal stenosis	11.62	NA	12.00	1.06	NA	24.68	090
30520		A	Repair of nasal septum	5.69	NA	6.68	0.46	NA	12.83	090
30540		A	Repair nasal defect	7.74	NA	9.30	0.67	NA	17.71	090
30545		A	Repair nasal defect	11.36	NA	11.93	1.70	NA	24.99	090
30560		A	Release of nasal adhesions	1.26	4.78	2.14	0.10	6.14	3.50	010
30580		A	Repair upper jaw fistula	6.68	7.79	5.81	0.89	15.36	13.38	090
30600		A	Repair mouth/nose fistula	6.01	7.54	5.03	0.70	14.25	11.74	090
30620		A	Intranasal reconstruction	5.96	NA	8.86	0.57	NA	15.39	090
30630		A	Repair nasal septum defect	7.11	NA	7.97	0.61	NA	15.69	090
30801		A	Ablate inf turbinate, superf	1.09	4.14	1.93	0.09	5.32	3.11	010
30802		A	Cauterization, inner nose	2.03	4.62	2.37	0.16	6.81	4.56	010
30901		A	Control of nosebleed	1.21	1.36	0.32	0.11	2.68	1.64	000
30903		A	Control of nosebleed	1.54	2.72	0.50	0.13	4.39	2.17	000
30905		A	Control of nosebleed	1.97	3.52	0.76	0.17	5.66	2.90	000
30906		A	Repeat control of nosebleed	2.45	3.90	1.20	0.20	6.55	3.85	000
30915		A	Ligation, nasal sinus artery	7.19	NA	6.71	0.58	NA	14.48	090
30920		A	Ligation, upper jaw artery	9.82	NA	9.00	0.80	NA	19.62	090
30930		A	Ther fx, nasal inf turbinate	1.26	NA	1.62	0.12	NA	3.00	010
30999		C	Nasal surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
31000		A	Irrigation, maxillary sinus	1.15	2.85	1.40	0.09	4.09	2.64	010
31002		A	Irrigation, sphenoid sinus	1.91	NA	3.25	0.15	NA	5.31	010
31020		A	Exploration, maxillary sinus	2.94	8.55	5.20	0.29	11.78	8.43	090
31030		A	Exploration, maxillary sinus	5.91	11.53	6.68	0.60	18.04	13.19	090
31032		A	Explore sinus, remove polyps	6.56	NA	7.25	0.59	NA	14.40	090
31040		A	Exploration behind upper jaw	9.41	NA	9.85	0.87	NA	20.13	090
31050		A	Exploration, sphenoid sinus	5.27	NA	6.37	0.49	NA	12.13	090
31051		A	Sphenoid sinus surgery	7.10	NA	8.26	0.62	NA	15.98	090
31070		A	Exploration of frontal sinus	4.27	NA	5.95	0.38	NA	10.60	090
31075		A	Exploration of frontal sinus	9.15	NA	9.76	0.75	NA	19.66	090
31080		A	Removal of frontal sinus	11.40	NA	13.57	1.23	NA	26.20	090
31081		A	Removal of frontal sinus	12.73	NA	14.04	2.46	NA	29.23	090
31084		A	Removal of frontal sinus	13.49	NA	13.54	1.19	NA	28.22	090
31085		A	Removal of frontal sinus	14.18	NA	14.00	1.72	NA	29.90	090
31086		A	Removal of frontal sinus	12.84	NA	13.32	1.07	NA	27.23	090
31087		A	Removal of frontal sinus	13.08	NA	12.57	1.44	NA	27.09	090
31090		A	Exploration of sinuses	9.52	NA	12.59	0.94	NA	23.05	090
31200		A	Removal of ethmoid sinus	4.96	NA	9.24	0.29	NA	14.49	090
31201		A	Removal of ethmoid sinus	8.36	NA	9.20	0.82	NA	18.38	090
31205		A	Removal of ethmoid sinus	10.22	NA	11.91	0.67	NA	22.80	090
31225		A	Removal of upper jaw	19.20	NA	17.87	1.59	NA	38.66	090
31230		A	Removal of upper jaw	21.91	NA	19.42	1.77	NA	43.10	090
31231		A	Nasal endoscopy, dx	1.10	3.39	0.88	0.09	4.58	2.07	000
31233		A	Nasal/sinus endoscopy, dx	2.18	4.31	1.48	0.20	6.69	3.86	000
31235		A	Nasal/sinus endoscopy, dx	2.64	4.92	1.72	0.26	7.82	4.62	000
31237		A	Nasal/sinus endoscopy, surg	2.98	5.21	1.89	0.28	8.47	5.15	000
31238		A	Nasal/sinus endoscopy, surg	3.26	5.25	2.10	0.27	8.78	5.63	000
31239		A	Nasal/sinus endoscopy, surg	8.69	NA	8.02	0.62	NA	17.33	010
31240		A	Nasal/sinus endoscopy, surg	2.61	NA	1.74	0.24	NA	4.59	000

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
31254	.....	A	Revision of ethmoid sinus	4.64	NA	2.86	0.45	NA	7.95	000
31255	.....	A	Removal of ethmoid sinus	6.95	NA	4.12	0.73	NA	11.80	000
31256	.....	A	Exploration maxillary sinus	3.29	NA	2.12	0.33	NA	5.74	000
31267	.....	A	Endoscopy, maxillary sinus	5.45	NA	3.30	0.55	NA	9.30	000
31276	.....	A	Sinus endoscopy, surgical	8.84	NA	5.13	0.92	NA	14.89	000
31287	.....	A	Nasal/sinus endoscopy, surg	3.91	NA	2.46	0.39	NA	6.76	000
31288	.....	A	Nasal/sinus endoscopy, surg	4.57	NA	2.82	0.46	NA	7.85	000
31290	.....	A	Nasal/sinus endoscopy, surg	17.21	NA	12.08	1.40	NA	30.69	010
31291	.....	A	Nasal/sinus endoscopy, surg	18.16	NA	12.51	1.68	NA	32.35	010
31292	.....	A	Nasal/sinus endoscopy, surg	14.74	NA	10.64	1.21	NA	26.59	010
31293	.....	A	Nasal/sinus endoscopy, surg	16.19	NA	11.41	1.28	NA	28.88	010
31294	.....	A	Nasal/sinus endoscopy, surg	19.03	NA	12.91	1.53	NA	33.47	010
31299	.....	C	Sinus surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
31300	.....	A	Removal of larynx lesion	14.27	NA	15.02	1.17	NA	30.46	090
31320	.....	A	Diagnostic incision, larynx	5.25	NA	10.33	0.46	NA	16.04	090
31360	.....	A	Removal of larynx	17.05	NA	16.77	1.38	NA	35.20	090
31365	.....	A	Removal of larynx	24.12	NA	20.42	1.97	NA	46.51	090
31367	.....	A	Partial removal of larynx	21.83	NA	21.95	1.78	NA	45.56	090
31368	.....	A	Partial removal of larynx	27.05	NA	25.56	2.20	NA	54.81	090
31370	.....	A	Partial removal of larynx	21.35	NA	22.32	1.74	NA	45.41	090
31375	.....	A	Partial removal of larynx	20.18	NA	20.44	1.63	NA	42.25	090
31380	.....	A	Partial removal of larynx	20.18	NA	20.66	1.70	NA	42.54	090
31382	.....	A	Partial removal of larynx	20.49	NA	21.67	1.67	NA	43.83	090
31390	.....	A	Removal of larynx & pharynx	27.49	NA	24.45	2.23	NA	54.17	090
31395	.....	A	Reconstruct larynx & pharynx	31.04	NA	28.38	2.48	NA	61.90	090
31400	.....	A	Revision of larynx	10.29	NA	13.81	0.83	NA	24.93	090
31420	.....	A	Removal of epiglottis	10.20	NA	9.57	0.83	NA	20.60	090
31500	.....	A	Insert emergency airway	2.33	NA	0.55	0.17	NA	3.05	000
31502	.....	A	Change of windpipe airway	0.65	0.31	0.28	0.05	1.01	0.98	000
31505	.....	A	Diagnostic laryngoscopy	0.61	1.45	0.61	0.05	2.11	1.27	000
31510	.....	A	Laryngoscopy with biopsy	1.92	3.31	1.25	0.16	5.39	3.33	000
31511	.....	A	Remove foreign body, larynx	2.16	3.13	1.06	0.19	5.48	3.41	000
31512	.....	A	Removal of larynx lesion	2.07	3.21	1.36	0.18	5.46	3.61	000
31513	.....	A	Injection into vocal cord	2.10	NA	1.46	0.17	NA	3.73	000
31515	.....	A	Laryngoscopy for aspiration	1.80	3.55	1.06	0.14	5.49	3.00	000
31520	.....	A	Dx laryngoscopy, newborn	2.56	NA	1.56	0.20	NA	4.32	000
31525	.....	A	Dx laryngoscopy excl nb	2.63	3.65	1.66	0.21	6.49	4.50	000
31526	.....	A	Dx laryngoscopy w/oper scope	2.57	NA	1.72	0.21	NA	4.50	000
31527	.....	A	Laryngoscopy for treatment	3.27	NA	1.88	0.26	NA	5.41	000
31528	.....	A	Laryngoscopy and dilation	2.37	NA	1.46	0.19	NA	4.02	000
31529	.....	A	Laryngoscopy and dilation	2.68	NA	1.71	0.22	NA	4.61	000
31530	.....	A	Laryngoscopy w/fb removal	3.38	NA	1.96	0.29	NA	5.63	000
31531	.....	A	Laryngoscopy w/fb & op scope	3.58	NA	2.28	0.29	NA	6.15	000
31535	.....	A	Laryngoscopy w/biopsy	3.16	NA	2.00	0.26	NA	5.42	000
31536	.....	A	Laryngoscopy w/bx & op scope	3.55	NA	2.26	0.29	NA	6.10	000
31540	.....	A	Laryngoscopy w/exc of tumor	4.12	NA	2.55	0.33	NA	7.00	000
31541	.....	A	Larynscop w/tumr exc + scope	4.52	NA	2.79	0.37	NA	7.68	000
31545	.....	A	Remove vc lesion w/scope	6.30	NA	3.48	0.37	NA	10.15	000
31546	.....	A	Remove vc lesion scope/graft	9.73	NA	4.98	0.78	NA	15.49	000
31560	.....	A	Laryngoscop w/arytenoidectom	5.45	NA	3.16	0.43	NA	9.04	000
31561	.....	A	Larynscop, remve cart + scop	5.99	NA	3.38	0.49	NA	9.86	000
31570	.....	A	Laryngoscope w/vc inj	3.86	5.69	2.39	0.31	9.86	6.56	000
31571	.....	A	Laryngoscop w/vc inj + scope	4.26	NA	2.61	0.35	NA	7.22	000
31575	.....	A	Diagnostic laryngoscopy	1.10	1.91	0.89	0.09	3.10	2.08	000
31576	.....	A	Laryngoscopy with biopsy	1.97	3.67	1.29	0.14	5.78	3.40	000
31577	.....	A	Remove foreign body, larynx	2.47	3.77	1.53	0.21	6.45	4.21	000
31578	.....	A	Removal of larynx lesion	2.84	4.29	1.52	0.23	7.36	4.59	000
31579	.....	A	Diagnostic laryngoscopy	2.26	3.79	1.48	0.18	6.23	3.92	000
31580	.....	A	Revision of larynx	12.36	NA	15.96	1.00	NA	29.32	090
31582	.....	A	Revision of larynx	21.59	NA	25.87	1.75	NA	49.21	090
31584	.....	A	Treat larynx fracture	19.61	NA	18.20	1.71	NA	39.52	090
31587	.....	A	Revision of larynx	11.97	NA	9.29	0.97	NA	22.23	090
31588	.....	A	Revision of larynx	13.09	NA	13.65	1.06	NA	27.80	090
31590	.....	A	Reinnervate larynx	6.96	NA	15.58	0.84	NA	23.38	090
31595	.....	A	Larynx nerve surgery	8.33	NA	10.58	0.68	NA	19.59	090
31599	.....	C	Larynx surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
31600	.....	A	Incision of windpipe	7.17	NA	3.20	0.80	NA	11.17	000
31601	.....	A	Incision of windpipe	4.44	NA	2.41	0.40	NA	7.25	000
31603	.....	A	Incision of windpipe	4.14	NA	1.71	0.44	NA	6.29	000
31605	.....	A	Incision of windpipe	3.57	NA	1.19	0.40	NA	5.16	000
31610	.....	A	Incision of windpipe	8.75	NA	8.28	0.79	NA	17.82	090
31611	.....	A	Surgery/speech prosthesis	5.63	NA	7.08	0.46	NA	13.17	090
31612	.....	A	Puncture/clear windpipe	0.91	1.10	0.35	0.08	2.09	1.34	000
31613	.....	A	Repair windpipe opening	4.58	NA	6.01	0.42	NA	11.01	090
31614	.....	A	Repair windpipe opening	7.11	NA	8.74	0.58	NA	16.43	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
31615	.....	A	Visualization of windpipe	2.09	2.60	1.20	0.16	4.85	3.45	000
31620	.....	A	Endobronchial us add-on	1.40	5.66	0.55	0.11	7.17	2.06	ZZZ
31622	.....	A	Dx bronchoscope/wash	2.78	5.67	1.06	0.18	8.63	4.02	000
31623	.....	A	Dx bronchoscope/brush	2.88	6.44	1.05	0.13	9.45	4.06	000
31624	.....	A	Dx bronchoscope/lavage	2.88	5.79	1.05	0.13	8.80	4.06	000
31625	.....	A	Bronchoscopy w/biopsy(s)	3.36	5.83	1.21	0.18	9.37	4.75	000
31628	.....	A	Bronchoscopy/lung bx, each	3.80	7.04	1.30	0.18	11.02	5.28	000
31629	.....	A	Bronchoscopy/needle bx, each	4.09	14.29	1.40	0.16	18.54	5.65	000
31630	.....	A	Bronchoscopy dilate/fx repr	3.81	NA	1.72	0.32	NA	5.85	000
31631	.....	A	Bronchoscopy, dilate w/stent	4.36	NA	1.77	0.34	NA	6.47	000
31632	.....	A	Bronchoscopy/lung bx, add'l	1.03	0.81	0.31	0.18	2.02	1.52	ZZZ
31633	.....	A	Bronchoscopy/needle bx add'l	1.32	0.92	0.40	0.16	2.40	1.88	ZZZ
31635	.....	A	Bronchoscopy w/fb removal	3.67	6.13	1.43	0.24	10.04	5.34	000
31636	.....	A	Bronchoscopy, bronch stents	4.30	NA	1.77	0.31	NA	6.38	000
31637	.....	A	Bronchoscopy, stent add-on	1.58	NA	0.56	0.13	NA	2.27	ZZZ
31638	.....	A	Bronchoscopy, revise stent	4.88	NA	1.98	0.22	NA	7.08	000
31640	.....	A	Bronchoscopy w/tumor excise	4.93	NA	2.08	0.46	NA	7.47	000
31641	.....	A	Bronchoscopy, treat blockage	5.02	NA	1.89	0.35	NA	7.26	000
31643	.....	A	Diag bronchoscope/catheter	3.49	NA	1.23	0.20	NA	4.92	000
31645	.....	A	Bronchoscopy, clear airways	3.16	5.15	1.12	0.16	8.47	4.44	000
31646	.....	A	Bronchoscopy, reclear airway	2.72	4.87	1.00	0.14	7.73	3.86	000
31656	.....	A	Bronchoscopy, inj for x-ray	2.17	7.31	0.83	0.15	9.63	3.15	000
31700	.....	A	Insertion of airway catheter	1.34	2.16	0.68	0.08	3.58	2.10	000
31708	.....	A	Instill airway contrast dye	1.41	2.04	0.46	0.07	3.52	1.94	000
31710	.....	A	Insertion of airway catheter	1.30	NA	0.41	0.12	NA	1.83	000
31715	.....	A	Injection for bronchus x-ray	1.11	NA	0.34	0.07	NA	1.52	000
31717	.....	A	Bronchial brush biopsy	2.12	8.27	0.79	0.14	10.53	3.05	000
31720	.....	A	Clearance of airways	1.06	0.33	0.33	0.07	1.46	1.46	000
31725	.....	A	Clearance of airways	1.96	0.65	0.58	0.14	2.75	2.68	000
31730	.....	A	Intro, windpipe wire/tube	2.85	2.20	1.00	0.21	5.26	4.06	000
31750	.....	A	Repair of windpipe	13.00	NA	17.60	1.05	NA	31.65	090
31755	.....	A	Repair of windpipe	15.91	NA	24.59	1.29	NA	41.79	090
31760	.....	A	Repair of windpipe	22.32	NA	10.74	2.94	NA	36.00	090
31766	.....	A	Reconstruction of windpipe	30.38	NA	13.69	4.52	NA	48.59	090
31770	.....	A	Repair/graft of bronchus	22.48	NA	10.27	2.83	NA	35.58	090
31775	.....	A	Reconstruct bronchus	23.50	NA	11.82	3.01	NA	38.33	090
31780	.....	A	Reconstruct windpipe	17.69	NA	11.08	1.65	NA	30.42	090
31781	.....	A	Reconstruct windpipe	23.49	NA	12.16	2.24	NA	37.89	090
31785	.....	A	Remove windpipe lesion	17.20	NA	10.21	1.59	NA	29.00	090
31786	.....	A	Remove windpipe lesion	23.94	NA	13.13	3.29	NA	40.36	090
31800	.....	A	Repair of windpipe injury	7.42	NA	9.27	0.79	NA	17.48	090
31805	.....	A	Repair of windpipe injury	13.11	NA	7.23	1.82	NA	22.16	090
31820	.....	A	Closure of windpipe lesion	4.48	5.68	3.66	0.38	10.54	8.52	090
31825	.....	A	Repair of windpipe defect	6.80	7.68	5.39	0.53	15.01	12.72	090
31830	.....	A	Revise windpipe scar	4.49	5.78	3.99	0.44	10.71	8.92	090
31899	.....	C	Airways surgical procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
32000	.....	A	Drainage of chest	1.54	3.06	0.48	0.08	4.68	2.10	000
32002	.....	A	Treatment of collapsed lung	2.19	3.22	1.06	0.12	5.53	3.37	000
32005	.....	A	Treat lung lining chemically	2.19	6.47	0.70	0.23	8.89	3.12	000
32019	.....	A	Insert pleural catheter	4.17	20.02	1.65	0.42	24.61	6.24	000
32020	.....	A	Insertion of chest tube	3.97	NA	1.35	0.43	NA	5.75	000
32035	.....	A	Exploration of chest	8.66	NA	5.87	1.26	NA	15.79	090
32036	.....	A	Exploration of chest	9.67	NA	6.45	1.43	NA	17.55	090
32095	.....	A	Biopsy through chest wall	8.35	NA	5.38	1.22	NA	14.95	090
32100	.....	A	Exploration/biopsy of chest	15.22	NA	7.84	2.23	NA	25.29	090
32110	.....	A	Explore/repair chest	22.97	NA	10.76	3.21	NA	36.94	090
32120	.....	A	Re-exploration of chest	11.52	NA	7.09	1.63	NA	20.24	090
32124	.....	A	Explore chest free adhesions	12.70	NA	7.23	1.89	NA	21.82	090
32140	.....	A	Removal of lung lesion(s)	13.91	NA	7.70	1.96	NA	23.57	090
32141	.....	A	Remove/treat lung lesions	13.98	NA	7.57	2.00	NA	23.55	090
32150	.....	A	Removal of lung lesion(s)	14.13	NA	7.62	2.00	NA	23.75	090
32151	.....	A	Remove lung foreign body	14.19	NA	8.02	2.03	NA	24.24	090
32160	.....	A	Open chest heart massage	9.29	NA	5.28	1.31	NA	15.88	090
32200	.....	A	Drain, open, lung lesion	15.27	NA	8.63	2.13	NA	26.03	090
32201	.....	A	Drain, percut, lung lesion	3.99	20.76	1.30	0.24	24.99	5.53	000
32215	.....	A	Treat chest lining	11.31	NA	6.92	1.68	NA	19.91	090
32220	.....	A	Release of lung	23.96	NA	12.99	3.56	NA	40.51	090
32225	.....	A	Partial release of lung	13.94	NA	7.67	2.06	NA	23.67	090
32310	.....	A	Removal of chest lining	13.42	NA	7.41	1.99	NA	22.82	090
32320	.....	A	Free/remove chest lining	23.96	NA	12.19	3.51	NA	39.66	090
32400	.....	A	Needle biopsy chest lining	1.76	2.13	0.55	0.10	3.99	2.41	000
32402	.....	A	Open biopsy chest lining	7.55	NA	5.12	1.07	NA	13.74	090
32405	.....	A	Biopsy, lung or mediastinum	1.93	0.67	0.63	0.11	2.71	2.67	000
32420	.....	A	Puncture/clear lung	2.18	NA	0.68	0.12	NA	2.98	000
32440	.....	A	Removal of lung	24.96	NA	12.93	3.68	NA	41.57	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
32442	.....	A	Sleeve pneumonectomy	26.20	NA	14.80	3.84	NA	44.84	090
32445	.....	A	Removal of lung	25.05	NA	14.10	3.71	NA	42.86	090
32480	.....	A	Partial removal of lung	23.71	NA	12.09	3.49	NA	39.29	090
32482	.....	A	Bilobectomy	24.96	NA	12.95	3.66	NA	41.57	090
32484	.....	A	Segmentectomy	20.66	NA	11.41	3.03	NA	35.10	090
32486	.....	A	Sleeve lobectomy	23.88	NA	13.28	3.51	NA	40.67	090
32488	.....	A	Completion pneumonectomy	25.67	NA	13.82	3.80	NA	43.29	090
32491	.....	R	Lung volume reduction	21.22	NA	12.66	2.98	NA	36.86	090
32500	.....	A	Partial removal of lung	21.97	NA	12.39	3.25	NA	37.61	090
32501	.....	A	Repair bronchus add-on	4.68	NA	1.54	0.65	NA	6.87	ZZZ
32503	.....	A	Resect apical lung tumor	30.00	NA	15.11	4.37	NA	49.48	090
32504	.....	A	Resect apical lung tum/chest	34.80	NA	16.72	5.07	NA	56.59	090
32540	.....	A	Removal of lung lesion	14.62	NA	9.66	2.07	NA	26.35	090
32601	.....	A	Thoracoscopy, diagnostic	5.45	NA	2.36	0.80	NA	8.61	000
32602	.....	A	Thoracoscopy, diagnostic	5.95	NA	2.53	0.87	NA	9.35	000
32603	.....	A	Thoracoscopy, diagnostic	7.80	NA	3.04	1.14	NA	11.98	000
32604	.....	A	Thoracoscopy, diagnostic	8.77	NA	3.46	1.25	NA	13.48	000
32605	.....	A	Thoracoscopy, diagnostic	6.92	NA	2.91	1.00	NA	10.83	000
32606	.....	A	Thoracoscopy, diagnostic	8.39	NA	3.34	1.22	NA	12.95	000
32650	.....	A	Thoracoscopy, surgical	10.73	NA	6.78	1.58	NA	19.09	090
32651	.....	A	Thoracoscopy, surgical	12.89	NA	7.25	1.86	NA	22.00	090
32652	.....	A	Thoracoscopy, surgical	18.63	NA	10.17	2.72	NA	31.52	090
32653	.....	A	Thoracoscopy, surgical	12.85	NA	6.99	1.88	NA	21.72	090
32654	.....	A	Thoracoscopy, surgical	12.42	NA	7.55	1.63	NA	21.60	090
32655	.....	A	Thoracoscopy, surgical	13.08	NA	7.26	1.89	NA	22.23	090
32656	.....	A	Thoracoscopy, surgical	12.89	NA	7.96	1.89	NA	22.74	090
32657	.....	A	Thoracoscopy, surgical	13.63	NA	7.70	1.99	NA	23.32	090
32658	.....	A	Thoracoscopy, surgical	11.61	NA	7.37	1.69	NA	20.67	090
32659	.....	A	Thoracoscopy, surgical	11.57	NA	7.47	1.62	NA	20.66	090
32660	.....	A	Thoracoscopy, surgical	17.40	NA	9.51	2.08	NA	28.99	090
32661	.....	A	Thoracoscopy, surgical	13.23	NA	7.81	1.92	NA	22.96	090
32662	.....	A	Thoracoscopy, surgical	16.42	NA	8.85	2.17	NA	27.44	090
32663	.....	A	Thoracoscopy, surgical	18.44	NA	10.79	2.72	NA	31.95	090
32664	.....	A	Thoracoscopy, surgical	14.18	NA	7.65	2.32	NA	24.15	090
32665	.....	A	Thoracoscopy, surgical	15.52	NA	8.15	2.15	NA	25.82	090
32800	.....	A	Repair lung hernia	13.67	NA	7.43	1.98	NA	23.08	090
32810	.....	A	Close chest after drainage	13.03	NA	7.54	1.93	NA	22.50	090
32815	.....	A	Close bronchial fistula	23.12	NA	11.00	3.27	NA	37.39	090
32820	.....	A	Reconstruct injured chest	21.45	NA	12.20	2.52	NA	36.17	090
32850	.....	X	Donor pneumonectomy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32851	.....	A	Lung transplant, single	38.57	NA	27.74	5.56	NA	71.87	090
32852	.....	A	Lung transplant with bypass	41.74	NA	33.26	6.00	NA	81.00	090
32853	.....	A	Lung transplant, double	47.74	NA	31.84	7.05	NA	86.63	090
32854	.....	A	Lung transplant with bypass	50.90	NA	34.83	7.20	NA	92.93	090
32855	.....	C	Prepare donor lung, single	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32856	.....	C	Prepare donor lung, double	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32900	.....	A	Removal of rib(s)	20.24	NA	9.91	2.93	NA	33.08	090
32905	.....	A	Revise & repair chest wall	20.72	NA	10.16	3.15	NA	34.03	090
32906	.....	A	Revise & repair chest wall	26.73	NA	12.09	3.97	NA	42.79	090
32940	.....	A	Revision of lung	19.40	NA	9.50	2.88	NA	31.78	090
32960	.....	A	Therapeutic pneumothorax	1.84	1.74	0.56	0.16	3.74	2.56	000
32997	.....	A	Total lung lavage	5.99	NA	1.92	0.55	NA	8.46	000
32999	.....	C	Chest surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
33010	.....	A	Drainage of heart sac	2.24	NA	0.78	0.14	NA	3.16	000
33011	.....	A	Repeat drainage of heart sac	2.24	NA	0.81	0.15	NA	3.20	000
33015	.....	A	Incision of heart sac	6.79	NA	4.96	0.65	NA	12.40	090
33020	.....	A	Incision of heart sac	12.59	NA	6.80	1.79	NA	21.18	090
33025	.....	A	Incision of heart sac	12.07	NA	6.37	1.80	NA	20.24	090
33030	.....	A	Partial removal of heart sac	18.68	NA	9.55	2.83	NA	31.06	090
33031	.....	A	Partial removal of heart sac	21.76	NA	10.06	3.13	NA	34.95	090
33050	.....	A	Removal of heart sac lesion	14.34	NA	7.86	2.14	NA	24.34	090
33120	.....	A	Removal of heart lesion	24.52	NA	11.61	3.69	NA	39.82	090
33130	.....	A	Removal of heart lesion	21.36	NA	10.14	3.00	NA	34.50	090
33140	.....	A	Heart revascularize (tmr)	19.97	NA	10.91	2.85	NA	33.73	090
33141	.....	A	Heart tmr w/other procedure	4.83	NA	1.58	0.69	NA	7.10	ZZZ
33200	.....	A	Insertion of heart pacemaker	12.46	NA	6.86	1.70	NA	21.02	090
33201	.....	A	Insertion of heart pacemaker	10.16	NA	6.60	1.36	NA	18.12	090
33206	.....	A	Insertion of heart pacemaker	6.66	NA	4.47	0.52	NA	11.65	090
33207	.....	A	Insertion of heart pacemaker	8.03	NA	4.67	0.59	NA	13.29	090
33208	.....	A	Insertion of heart pacemaker	8.12	NA	4.78	0.56	NA	13.46	090
33210	.....	A	Insertion of heart electrode	3.30	NA	1.25	0.18	NA	4.73	000
33211	.....	A	Insertion of heart electrode	3.39	NA	1.31	0.21	NA	4.91	000
33212	.....	A	Insertion of pulse generator	5.51	NA	3.37	0.43	NA	9.31	090
33213	.....	A	Insertion of pulse generator	6.36	NA	3.73	0.45	NA	10.54	090
33214	.....	A	Upgrade of pacemaker system	7.74	NA	4.90	0.58	NA	13.22	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
33215	.....	A	Reposition pacing-defib lead	4.75	NA	3.19	0.37	NA	8.31	090
33216	.....	A	Insert lead pace-defib, one	5.77	NA	4.21	0.36	NA	10.34	090
33217	.....	A	Insert lead pace-defib, dual	5.74	NA	4.24	0.39	NA	10.37	090
33218	.....	A	Repair lead pace-defib, one	5.43	NA	4.31	0.37	NA	10.11	090
33220	.....	A	Repair lead pace-defib, dual	5.51	NA	4.28	0.37	NA	10.16	090
33222	.....	A	Revise pocket, pacemaker	4.95	NA	4.30	0.42	NA	9.67	090
33223	.....	A	Revise pocket, pacing-defib	6.45	NA	4.60	0.45	NA	11.50	090
33224	.....	A	Insert pacing lead & connect	9.04	NA	4.01	0.54	NA	13.59	000
33225	.....	A	L ventric pacing lead add-on	8.33	NA	3.26	0.45	NA	12.04	ZZZ
33226	.....	A	Reposition l ventric lead	8.68	NA	3.83	0.59	NA	13.10	000
33233	.....	A	Removal of pacemaker system	3.29	NA	3.28	0.22	NA	6.79	090
33234	.....	A	Removal of pacemaker system	7.81	NA	4.92	0.56	NA	13.29	090
33235	.....	A	Removal pacemaker electrode	9.39	NA	6.83	0.73	NA	16.95	090
33236	.....	A	Remove electrode/thoracotomy	12.58	NA	7.45	1.68	NA	21.71	090
33237	.....	A	Remove electrode/thoracotomy	13.69	NA	7.80	1.59	NA	23.08	090
33238	.....	A	Remove electrode/thoracotomy	15.20	NA	8.22	2.02	NA	25.44	090
33240	.....	A	Insert pulse generator	7.59	NA	4.59	0.41	NA	12.59	090
33241	.....	A	Remove pulse generator	3.24	NA	2.97	0.18	NA	6.39	090
33243	.....	A	Remove eltrd/thoracotomy	22.61	NA	11.49	2.09	NA	36.19	090
33244	.....	A	Remove eltrd, transven	13.74	NA	8.92	0.99	NA	23.65	090
33245	.....	A	Insert epic eltrd pace-defib	14.28	NA	7.92	2.01	NA	24.21	090
33246	.....	A	Insert epic eltrd/generator	20.68	NA	10.31	2.63	NA	33.62	090
33249	.....	A	Eltrd/insert pace-defib	14.21	NA	8.38	0.77	NA	23.36	090
33250	.....	A	Ablate heart dysrhythm focus	21.82	NA	11.05	3.18	NA	36.05	090
33251	.....	A	Ablate heart dysrhythm focus	24.84	NA	11.69	3.59	NA	40.12	090
33253	.....	A	Reconstruct atria	31.01	NA	13.86	4.52	NA	49.39	090
33261	.....	A	Ablate heart dysrhythm focus	24.84	NA	11.80	3.45	NA	40.09	090
33282	.....	A	Implant pat-active ht record	4.16	NA	4.03	0.23	NA	8.42	090
33284	.....	A	Remove pat-active ht record	2.50	NA	3.54	0.14	NA	6.18	090
33300	.....	A	Repair of heart wound	17.89	NA	9.26	2.65	NA	29.80	090
33305	.....	A	Repair of heart wound	21.41	NA	10.64	3.12	NA	35.17	090
33310	.....	A	Exploratory heart surgery	18.48	NA	9.61	2.58	NA	30.67	090
33315	.....	A	Exploratory heart surgery	22.34	NA	10.91	3.27	NA	36.52	090
33320	.....	A	Repair major blood vessel(s)	16.76	NA	8.24	2.07	NA	27.07	090
33321	.....	A	Repair major vessel	20.17	NA	9.81	2.90	NA	32.88	090
33322	.....	A	Repair major blood vessel(s)	20.59	NA	10.39	2.85	NA	33.83	090
33330	.....	A	Insert major vessel graft	21.40	NA	10.29	2.81	NA	34.50	090
33332	.....	A	Insert major vessel graft	23.92	NA	10.54	3.02	NA	37.48	090
33335	.....	A	Insert major vessel graft	29.96	NA	13.37	4.27	NA	47.60	090
33400	.....	A	Repair of aortic valve	28.46	NA	15.71	4.10	NA	48.27	090
33401	.....	A	Valvuloplasty, open	23.87	NA	13.54	3.56	NA	40.97	090
33403	.....	A	Valvuloplasty, w/cp bypass	24.85	NA	14.34	3.54	NA	42.73	090
33404	.....	A	Prepare heart-aorta conduit	28.50	NA	14.58	4.32	NA	47.40	090
33405	.....	A	Replacement of aortic valve	34.95	NA	18.34	5.31	NA	58.60	090
33406	.....	A	Replacement of aortic valve	37.44	NA	19.18	5.43	NA	62.05	090
33410	.....	A	Replacement of aortic valve	32.41	NA	16.63	4.68	NA	53.72	090
33411	.....	A	Replacement of aortic valve	36.20	NA	18.79	5.46	NA	60.45	090
33412	.....	A	Replacement of aortic valve	41.94	NA	20.46	6.37	NA	68.77	090
33413	.....	A	Replacement of aortic valve	43.43	NA	20.87	6.51	NA	70.81	090
33414	.....	A	Repair of aortic valve	30.30	NA	14.17	4.56	NA	49.03	090
33415	.....	A	Revision, subvalvular tissue	27.11	NA	12.05	4.13	NA	43.29	090
33416	.....	A	Revise ventricle muscle	30.30	NA	13.54	4.56	NA	48.40	090
33417	.....	A	Repair of aortic valve	28.49	NA	13.65	4.09	NA	46.23	090
33420	.....	A	Revision of mitral valve	22.67	NA	9.59	1.81	NA	34.07	090
33422	.....	A	Revision of mitral valve	25.90	NA	13.69	3.93	NA	43.52	090
33425	.....	A	Repair of mitral valve	26.96	NA	13.09	4.06	NA	44.11	090
33426	.....	A	Repair of mitral valve	32.95	NA	17.18	5.01	NA	55.14	090
33427	.....	A	Repair of mitral valve	39.94	NA	19.42	6.07	NA	65.43	090
33430	.....	A	Replacement of mitral valve	33.45	NA	17.34	5.08	NA	55.87	090
33460	.....	A	Revision of tricuspid valve	23.56	NA	11.33	3.44	NA	38.33	090
33463	.....	A	Valvuloplasty, tricuspid	25.58	NA	12.95	3.86	NA	42.39	090
33464	.....	A	Valvuloplasty, tricuspid	27.29	NA	13.56	4.14	NA	44.99	090
33465	.....	A	Replace tricuspid valve	28.75	NA	13.00	4.38	NA	46.13	090
33468	.....	A	Revision of tricuspid valve	30.07	NA	13.69	4.06	NA	47.82	090
33470	.....	A	Revision of pulmonary valve	20.78	NA	10.72	1.03	NA	32.53	090
33471	.....	A	Valvotomy, pulmonary valve	22.22	NA	9.78	3.38	NA	35.38	090
33472	.....	A	Revision of pulmonary valve	22.22	NA	11.89	3.54	NA	37.65	090
33474	.....	A	Revision of pulmonary valve	23.01	NA	10.91	3.21	NA	37.13	090
33475	.....	A	Replacement, pulmonary valve	32.95	NA	15.41	4.92	NA	53.28	090
33476	.....	A	Revision of heart chamber	25.73	NA	11.99	2.41	NA	40.13	090
33478	.....	A	Revision of heart chamber	26.70	NA	13.09	3.88	NA	43.67	090
33496	.....	A	Repair, prosth valve clot	27.21	NA	12.78	4.12	NA	44.11	090
33500	.....	A	Repair heart vessel fistula	25.51	NA	11.49	3.86	NA	40.86	090
33501	.....	A	Repair heart vessel fistula	17.75	NA	8.30	1.90	NA	27.95	090
33502	.....	A	Coronary artery correction	21.01	NA	11.10	2.99	NA	35.10	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
33503	.....	A	Coronary artery graft	21.75	NA	9.76	1.77	NA	33.28	090
33504	.....	A	Coronary artery graft	24.62	NA	11.84	3.35	NA	39.81	090
33505	.....	A	Repair artery w/tunnel	26.80	NA	12.94	2.18	NA	41.92	090
33506	.....	A	Repair artery, translocation	35.45	NA	14.60	4.65	NA	54.70	090
33507	.....	A	Repair art, intramural	30.00	NA	13.68	4.05	NA	47.73	090
33508	.....	A	Endoscopic vein harvest	0.31	NA	0.10	0.04	NA	0.45	ZZZ
33510	.....	A	CABG, vein, single	28.96	NA	16.38	4.40	NA	49.74	090
33511	.....	A	CABG, vein, two	29.96	NA	17.12	4.55	NA	51.63	090
33512	.....	A	CABG, vein, three	31.75	NA	17.65	4.66	NA	54.06	090
33513	.....	A	CABG, vein, four	31.95	NA	17.83	4.87	NA	54.65	090
33514	.....	A	CABG, vein, five	32.70	NA	18.10	4.76	NA	55.56	090
33516	.....	A	Cabg, vein, six or more	34.95	NA	18.85	5.11	NA	58.91	090
33517	.....	A	CABG, artery-vein, single	2.57	NA	0.84	0.39	NA	3.80	ZZZ
33518	.....	A	CABG, artery-vein, two	4.84	NA	1.58	0.73	NA	7.15	ZZZ
33519	.....	A	CABG, artery-vein, three	7.11	NA	2.33	1.04	NA	10.48	ZZZ
33521	.....	A	CABG, artery-vein, four	9.39	NA	3.08	1.37	NA	13.84	ZZZ
33522	.....	A	CABG, artery-vein, five	11.65	NA	3.82	1.77	NA	17.24	ZZZ
33523	.....	A	Cabg, art-vein, six or more	13.93	NA	4.54	2.12	NA	20.59	ZZZ
33530	.....	A	Coronary artery, bypass/reop	5.85	NA	1.92	0.88	NA	8.65	ZZZ
33533	.....	A	CABG, arterial, single	29.96	NA	16.51	4.55	NA	51.02	090
33534	.....	A	CABG, arterial, two	32.15	NA	17.76	4.69	NA	54.60	090
33535	.....	A	CABG, arterial, three	34.45	NA	18.18	5.01	NA	57.64	090
33536	.....	A	Cabg, arterial, four or more	37.44	NA	18.34	5.42	NA	61.20	090
33542	.....	A	Removal of heart lesion	28.81	NA	13.03	4.37	NA	46.21	090
33545	.....	A	Repair of heart damage	36.72	NA	15.67	5.19	NA	57.58	090
33548	.....	A	Restore/remodel, ventricle	37.97	NA	19.35	5.51	NA	62.83	090
33572	.....	A	Open coronary endarterectomy	4.44	NA	1.45	0.65	NA	6.54	ZZZ
33600	.....	A	Closure of valve	29.47	NA	12.55	4.41	NA	46.43	090
33602	.....	A	Closure of valve	28.50	NA	12.48	3.81	NA	44.79	090
33606	.....	A	Anastomosis/artery-aorta	30.69	NA	13.71	4.40	NA	48.80	090
33608	.....	A	Repair anomaly w/conduit	31.04	NA	14.14	4.73	NA	49.91	090
33610	.....	A	Repair by enlargement	30.56	NA	13.64	4.55	NA	48.75	090
33611	.....	A	Repair double ventricle	33.95	NA	14.17	4.36	NA	52.48	090
33612	.....	A	Repair double ventricle	34.95	NA	15.19	5.28	NA	55.42	090
33615	.....	A	Repair, modified fontan	33.95	NA	13.18	4.31	NA	51.44	090
33617	.....	A	Repair single ventricle	36.94	NA	16.04	5.64	NA	58.62	090
33619	.....	A	Repair single ventricle	44.93	NA	20.86	6.44	NA	72.23	090
33641	.....	A	Repair heart septum defect	21.36	NA	9.60	3.22	NA	34.18	090
33645	.....	A	Revision of heart veins	24.78	NA	11.80	3.78	NA	40.36	090
33647	.....	A	Repair heart septum defects	28.69	NA	13.81	3.31	NA	45.81	090
33660	.....	A	Repair of heart defects	29.96	NA	13.52	4.48	NA	47.96	090
33665	.....	A	Repair of heart defects	28.56	NA	13.87	3.99	NA	46.42	090
33670	.....	A	Repair of heart chambers	34.95	NA	13.21	4.64	NA	52.80	090
33681	.....	A	Repair heart septum defect	30.56	NA	14.72	4.44	NA	49.72	090
33684	.....	A	Repair heart septum defect	29.61	NA	13.66	3.38	NA	46.65	090
33688	.....	A	Repair heart septum defect	30.57	NA	10.50	4.72	NA	45.79	090
33690	.....	A	Reinforce pulmonary artery	19.52	NA	10.19	1.96	NA	31.67	090
33692	.....	A	Repair of heart defects	30.70	NA	13.96	4.57	NA	49.23	090
33694	.....	A	Repair of heart defects	33.95	NA	14.26	5.26	NA	53.47	090
33697	.....	A	Repair of heart defects	35.95	NA	14.91	4.08	NA	54.94	090
33702	.....	A	Repair of heart defects	26.50	NA	12.60	3.67	NA	42.77	090
33710	.....	A	Repair of heart defects	29.67	NA	14.00	4.42	NA	48.09	090
33720	.....	A	Repair of heart defect	26.52	NA	12.32	3.83	NA	42.67	090
33722	.....	A	Repair of heart defect	28.37	NA	13.89	1.30	NA	43.56	090
33730	.....	A	Repair heart-vein defect(s)	34.20	NA	14.16	5.01	NA	53.37	090
33732	.....	A	Repair heart-vein defect	28.12	NA	13.42	3.67	NA	45.21	090
33735	.....	A	Revision of heart chamber	21.36	NA	8.98	1.91	NA	32.25	090
33736	.....	A	Revision of heart chamber	23.48	NA	11.88	3.08	NA	38.44	090
33737	.....	A	Revision of heart chamber	21.73	NA	10.96	3.24	NA	35.93	090
33750	.....	A	Major vessel shunt	21.38	NA	10.24	1.16	NA	32.78	090
33755	.....	A	Major vessel shunt	21.76	NA	8.83	3.25	NA	33.84	090
33762	.....	A	Major vessel shunt	21.76	NA	10.18	3.13	NA	35.07	090
33764	.....	A	Major vessel shunt & graft	21.76	NA	10.25	3.00	NA	35.01	090
33766	.....	A	Major vessel shunt	22.73	NA	11.70	3.69	NA	38.12	090
33767	.....	A	Major vessel shunt	24.46	NA	11.75	3.81	NA	40.02	090
33768	.....	A	Cavopulmonary shunting	8.00	NA	2.67	1.19	NA	11.86	ZZZ
33770	.....	A	Repair great vessels defect	36.94	NA	14.72	5.72	NA	57.38	090
33771	.....	A	Repair great vessels defect	34.60	NA	12.42	5.66	NA	52.68	090
33774	.....	A	Repair great vessels defect	30.93	NA	14.70	4.80	NA	50.43	090
33775	.....	A	Repair great vessels defect	32.15	NA	15.03	4.98	NA	52.16	090
33776	.....	A	Repair great vessels defect	33.99	NA	15.85	5.07	NA	54.91	090
33777	.....	A	Repair great vessels defect	33.41	NA	15.66	5.47	NA	54.54	090
33778	.....	A	Repair great vessels defect	39.94	NA	16.94	6.18	NA	63.06	090
33779	.....	A	Repair great vessels defect	36.16	NA	15.41	2.91	NA	54.48	090
33780	.....	A	Repair great vessels defect	41.69	NA	19.14	3.67	NA	64.50	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
33781	.....	A	Repair great vessels defect	36.40	NA	13.37	5.95	NA	55.72	090
33786	.....	A	Repair arterial trunk	38.94	NA	16.76	5.69	NA	61.39	090
33788	.....	A	Revision of pulmonary artery	26.58	NA	11.98	4.02	NA	42.58	090
33800	.....	A	Aortic suspension	16.22	NA	8.13	2.45	NA	26.80	090
33802	.....	A	Repair vessel defect	17.63	NA	9.25	2.26	NA	29.14	090
33803	.....	A	Repair vessel defect	19.57	NA	9.79	3.19	NA	32.55	090
33813	.....	A	Repair septal defect	20.62	NA	10.94	3.12	NA	34.68	090
33814	.....	A	Repair septal defect	25.73	NA	12.68	3.84	NA	42.25	090
33820	.....	A	Revise major vessel	16.27	NA	8.38	2.34	NA	26.99	090
33822	.....	A	Revise major vessel	17.29	NA	8.98	2.67	NA	28.94	090
33824	.....	A	Revise major vessel	19.49	NA	10.01	2.88	NA	32.38	090
33840	.....	A	Remove aorta constriction	20.60	NA	10.32	2.15	NA	33.07	090
33845	.....	A	Remove aorta constriction	22.09	NA	11.38	3.21	NA	36.68	090
33851	.....	A	Remove aorta constriction	21.24	NA	10.71	3.17	NA	35.12	090
33852	.....	A	Repair septal defect	23.67	NA	11.39	2.15	NA	37.21	090
33853	.....	A	Repair septal defect	31.67	NA	14.86	4.47	NA	51.00	090
33860	.....	A	Ascending aortic graft	37.94	NA	16.50	5.74	NA	60.18	090
33861	.....	A	Ascending aortic graft	41.94	NA	17.76	6.35	NA	66.05	090
33863	.....	A	Ascending aortic graft	44.93	NA	18.74	6.57	NA	70.24	090
33870	.....	A	Transverse aortic arch graft	43.93	NA	18.43	6.60	NA	68.96	090
33875	.....	A	Thoracic aortic graft	33.01	NA	14.13	4.88	NA	52.02	090
33877	.....	A	Thoracoabdominal graft	42.54	NA	16.36	5.92	NA	64.82	090
33880	.....	A	Endovasc taa repr incl subcl	33.00	NA	13.51	2.74	NA	49.25	090
33881	.....	A	Endovasc taa repr w/o subcl	28.00	NA	11.99	2.32	NA	42.31	090
33883	.....	A	Insert endovasc prosth, taa	20.00	NA	9.21	2.10	NA	31.31	090
33884	.....	A	Endovasc prosth, taa, add-on	8.20	NA	2.58	0.86	NA	11.64	ZZZ
33886	.....	A	Endovasc prosth, delayed	17.00	NA	8.25	1.79	NA	27.04	090
33889	.....	A	Artery transpose/endovas taa	15.92	NA	5.19	2.17	NA	23.28	000
33891	.....	A	Car-car bp grft/endovas taa	20.00	NA	6.98	2.72	NA	29.70	000
33910	.....	A	Remove lung artery emboli	24.55	NA	11.46	3.69	NA	39.70	090
33915	.....	A	Remove lung artery emboli	20.99	NA	9.66	1.44	NA	32.09	090
33916	.....	A	Surgery of great vessel	25.79	NA	11.37	3.66	NA	40.82	090
33917	.....	A	Repair pulmonary artery	24.46	NA	12.22	3.69	NA	40.37	090
33920	.....	A	Repair pulmonary atresia	31.90	NA	13.86	4.37	NA	50.13	090
33922	.....	A	Transect pulmonary artery	23.48	NA	10.93	3.09	NA	37.50	090
33924	.....	A	Remove pulmonary shunt	5.49	NA	1.85	0.82	NA	8.16	ZZZ
33925	.....	A	Rpr pul art unifocal w/o cpb	29.50	NA	14.70	4.60	NA	48.80	090
33926	.....	A	Repr pul art, unifocal w/cpb	42.00	NA	17.73	6.20	NA	65.93	090
33930	.....	X	Removal of donor heart/lung	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33933	.....	C	Prepare donor heart/lung	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33935	.....	R	Transplantation, heart/lung	60.87	NA	28.85	9.03	NA	98.75	090
33940	.....	X	Removal of donor heart	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33944	.....	C	Prepare donor heart	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33945	.....	R	Transplantation of heart	42.04	NA	21.45	6.24	NA	69.73	090
33960	.....	A	External circulation assist	19.33	NA	4.92	2.66	NA	26.91	000
33961	.....	A	External circulation assist	10.91	NA	3.62	0.88	NA	15.41	ZZZ
33967	.....	A	Insert ia percut device	4.84	NA	1.85	0.35	NA	7.04	000
33968	.....	A	Remove aortic assist device	0.64	NA	0.23	0.07	NA	0.94	000
33970	.....	A	Aortic circulation assist	6.74	NA	2.29	0.82	NA	9.85	000
33971	.....	A	Aortic circulation assist	9.68	NA	6.02	1.25	NA	16.95	090
33973	.....	A	Insert balloon device	9.75	NA	3.32	1.26	NA	14.33	000
33974	.....	A	Remove intra-aortic balloon	14.39	NA	7.90	1.73	NA	24.02	090
33975	.....	A	Implant ventricular device	20.97	NA	6.30	3.06	NA	30.33	XXX
33976	.....	A	Implant ventricular device	22.97	NA	7.57	3.25	NA	33.79	XXX
33977	.....	A	Remove ventricular device	19.26	NA	11.10	2.80	NA	33.16	090
33978	.....	A	Remove ventricular device	21.70	NA	11.78	3.30	NA	36.78	090
33979	.....	A	Insert intracorporeal device	45.93	NA	14.96	6.95	NA	67.84	XXX
33980	.....	A	Remove intracorporeal device	56.17	NA	25.31	8.56	NA	90.04	090
33999	.....	C	Cardiac surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
34001	.....	A	Removal of artery clot	12.89	NA	6.73	1.84	NA	21.46	090
34051	.....	A	Removal of artery clot	15.19	NA	7.80	2.20	NA	25.19	090
34101	.....	A	Removal of artery clot	9.99	NA	5.37	1.41	NA	16.77	090
34111	.....	A	Removal of arm artery clot	9.99	NA	5.37	1.40	NA	16.76	090
34151	.....	A	Removal of artery clot	24.96	NA	10.43	3.55	NA	38.94	090
34201	.....	A	Removal of artery clot	10.01	NA	5.43	1.45	NA	16.89	090
34203	.....	A	Removal of leg artery clot	16.48	NA	8.08	2.35	NA	26.91	090
34401	.....	A	Removal of vein clot	24.96	NA	10.69	3.09	NA	38.74	090
34421	.....	A	Removal of vein clot	11.98	NA	6.31	1.55	NA	19.84	090
34451	.....	A	Removal of vein clot	26.96	NA	11.47	3.83	NA	42.26	090
34471	.....	A	Removal of vein clot	10.16	NA	5.32	1.18	NA	16.66	090
34490	.....	A	Removal of vein clot	9.85	NA	5.44	1.41	NA	16.70	090
34501	.....	A	Repair valve, femoral vein	15.98	NA	8.51	2.34	NA	26.83	090
34502	.....	A	Reconstruct vena cava	26.91	NA	12.33	3.62	NA	42.86	090
34510	.....	A	Transposition of vein valve	18.92	NA	9.44	2.32	NA	30.68	090
34520	.....	A	Cross-over vein graft	17.92	NA	8.47	2.28	NA	28.67	090

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[3] +Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
34530	.....	A	Leg vein fusion	16.62	NA	8.63	1.73	NA	26.98	090
34800	.....	A	Endovas aaa repr w/sm tube	20.72	NA	9.19	2.45	NA	32.36	090
34802	.....	A	Endovas aaa repr w/2-p part	22.97	NA	9.81	2.32	NA	35.10	090
34803	.....	A	Endovas aaa repr w/3-p part	24.00	NA	10.24	2.00	NA	36.24	090
34804	.....	A	Endovas aaa repr w/1-p part	22.97	NA	9.83	2.29	NA	35.09	090
34805	.....	A	Endovas aaa repr w/long tube	21.85	NA	9.67	2.00	NA	33.52	090
34808	.....	A	Endovas iliac a device addon	4.12	NA	1.37	0.59	NA	6.08	ZZZ
34812	.....	A	Xpose for endoprosth, femorl	6.74	NA	2.24	1.18	NA	10.16	000
34813	.....	A	Femoral endovas graft add-on	4.79	NA	1.57	0.67	NA	7.03	ZZZ
34820	.....	A	Xpose for endoprosth, iliac	9.74	NA	3.24	1.50	NA	14.48	000
34825	.....	A	Endovasc extend prosth, init	11.98	NA	6.16	1.28	NA	19.42	090
34826	.....	A	Endovasc exten prosth, add'l	4.12	NA	1.37	0.44	NA	5.93	ZZZ
34830	.....	A	Open aortic tube prosth repr	32.54	NA	13.73	4.54	NA	50.81	090
34831	.....	A	Open aortoiliac prosth repr	35.29	NA	11.76	4.88	NA	51.93	090
34832	.....	A	Open aortofemor prosth repr	35.29	NA	14.66	4.84	NA	54.79	090
34833	.....	A	Xpose for endoprosth, iliac	11.98	NA	4.44	1.69	NA	18.11	000
34834	.....	A	Xpose, endoprosth, brachial	5.34	NA	2.20	0.76	NA	8.30	000
34900	.....	A	Endovasc iliac repr w/graft	16.36	NA	7.60	1.99	NA	25.95	090
35001	.....	A	Repair defect of artery	19.61	NA	9.58	2.80	NA	31.99	090
35002	.....	A	Repair artery rupture, neck	20.97	NA	9.72	2.99	NA	33.68	090
35005	.....	A	Repair defect of artery	18.09	NA	8.87	1.76	NA	28.72	090
35011	.....	A	Repair defect of artery	17.97	NA	8.00	2.54	NA	28.51	090
35013	.....	A	Repair artery rupture, arm	21.97	NA	9.70	3.09	NA	34.76	090
35021	.....	A	Repair defect of artery	19.62	NA	9.44	2.86	NA	31.92	090
35022	.....	A	Repair artery rupture, chest	23.15	NA	9.88	3.16	NA	36.19	090
35045	.....	A	Repair defect of arm artery	17.54	NA	7.52	2.44	NA	27.50	090
35081	.....	A	Repair defect of artery	27.97	NA	11.49	4.00	NA	43.46	090
35082	.....	A	Repair artery rupture, aorta	38.44	NA	15.33	5.42	NA	59.19	090
35091	.....	A	Repair defect of artery	35.35	NA	13.60	5.12	NA	54.07	090
35092	.....	A	Repair artery rupture, aorta	44.93	NA	17.68	6.38	NA	68.99	090
35102	.....	A	Repair defect of artery	30.71	NA	12.39	4.47	NA	47.57	090
35103	.....	A	Repair artery rupture, groin	40.44	NA	15.89	5.74	NA	62.07	090
35111	.....	A	Repair defect of artery	24.96	NA	10.49	3.46	NA	38.91	090
35112	.....	A	Repair artery rupture,spleen	29.96	NA	11.99	4.07	NA	46.02	090
35121	.....	A	Repair defect of artery	29.96	NA	12.40	4.29	NA	46.65	090
35122	.....	A	Repair artery rupture, belly	34.95	NA	13.84	4.74	NA	53.53	090
35131	.....	A	Repair defect of artery	24.96	NA	10.77	3.79	NA	39.52	090
35132	.....	A	Repair artery rupture, groin	29.96	NA	12.41	4.29	NA	46.66	090
35141	.....	A	Repair defect of artery	19.97	NA	8.94	2.89	NA	31.80	090
35142	.....	A	Repair artery rupture, thigh	23.27	NA	10.39	3.35	NA	37.01	090
35151	.....	A	Repair defect of artery	22.61	NA	10.01	3.23	NA	35.85	090
35152	.....	A	Repair artery rupture, knee	25.58	NA	11.40	3.60	NA	40.58	090
35180	.....	A	Repair blood vessel lesion	13.60	NA	6.96	1.00	NA	21.56	090
35182	.....	A	Repair blood vessel lesion	29.96	NA	12.83	4.35	NA	47.14	090
35184	.....	A	Repair blood vessel lesion	17.97	NA	8.31	2.52	NA	28.80	090
35188	.....	A	Repair blood vessel lesion	14.26	NA	7.65	2.15	NA	24.06	090
35189	.....	A	Repair blood vessel lesion	27.96	NA	11.98	4.00	NA	43.94	090
35190	.....	A	Repair blood vessel lesion	12.73	NA	6.49	1.79	NA	21.01	090
35201	.....	A	Repair blood vessel lesion	16.12	NA	8.01	2.33	NA	26.46	090
35206	.....	A	Repair blood vessel lesion	13.23	NA	6.57	1.86	NA	21.66	090
35207	.....	A	Repair blood vessel lesion	10.13	NA	7.37	1.48	NA	18.98	090
35211	.....	A	Repair blood vessel lesion	22.09	NA	10.64	3.19	NA	35.92	090
35216	.....	A	Repair blood vessel lesion	18.72	NA	9.00	2.64	NA	30.36	090
35221	.....	A	Repair blood vessel lesion	24.35	NA	9.96	3.36	NA	37.67	090
35226	.....	A	Repair blood vessel lesion	14.48	NA	7.45	2.01	NA	23.94	090
35231	.....	A	Repair blood vessel lesion	19.97	NA	9.79	2.88	NA	32.64	090
35236	.....	A	Repair blood vessel lesion	17.08	NA	7.90	2.42	NA	27.40	090
35241	.....	A	Repair blood vessel lesion	23.09	NA	11.15	3.52	NA	37.76	090
35246	.....	A	Repair blood vessel lesion	26.41	NA	11.45	3.85	NA	41.71	090
35251	.....	A	Repair blood vessel lesion	30.15	NA	11.82	4.12	NA	46.09	090
35256	.....	A	Repair blood vessel lesion	18.33	NA	8.37	2.62	NA	29.32	090
35261	.....	A	Repair blood vessel lesion	17.77	NA	8.03	2.60	NA	28.40	090
35266	.....	A	Repair blood vessel lesion	14.89	NA	7.02	2.09	NA	24.00	090
35271	.....	A	Repair blood vessel lesion	22.09	NA	10.54	3.15	NA	35.78	090
35276	.....	A	Repair blood vessel lesion	24.21	NA	11.23	3.48	NA	38.92	090
35281	.....	A	Repair blood vessel lesion	27.96	NA	11.73	3.96	NA	43.65	090
35286	.....	A	Repair blood vessel lesion	16.14	NA	8.07	2.34	NA	26.55	090
35301	.....	A	Rechanneling of artery	18.67	NA	8.45	2.67	NA	29.79	090
35311	.....	A	Rechanneling of artery	26.96	NA	11.77	3.41	NA	42.14	090
35321	.....	A	Rechanneling of artery	15.98	NA	7.40	2.24	NA	25.62	090
35331	.....	A	Rechanneling of artery	26.16	NA	11.26	3.82	NA	41.24	090
35341	.....	A	Rechanneling of artery	25.07	NA	10.89	3.77	NA	39.73	090
35351	.....	A	Rechanneling of artery	22.97	NA	9.62	3.34	NA	35.93	090
35355	.....	A	Rechanneling of artery	18.47	NA	8.10	2.66	NA	29.23	090
35361	.....	A	Rechanneling of artery	28.16	NA	11.73	4.14	NA	44.03	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
35363	.....	A	Rechanneling of artery	30.15	NA	12.62	4.32	NA	47.09	090
35371	.....	A	Rechanneling of artery	14.70	NA	6.97	2.13	NA	23.80	090
35372	.....	A	Rechanneling of artery	17.97	NA	8.06	2.62	NA	28.65	090
35381	.....	A	Rechanneling of artery	15.79	NA	7.83	2.25	NA	25.87	090
35390	.....	A	Reoperation, carotid add-on	3.19	NA	1.06	0.46	NA	4.71	ZZZ
35400	.....	A	Angioscopy	3.00	NA	1.11	0.43	NA	4.54	ZZZ
35450	.....	A	Repair arterial blockage	10.05	NA	3.57	1.25	NA	14.87	000
35452	.....	A	Repair arterial blockage	6.90	NA	2.61	0.94	NA	10.45	000
35454	.....	A	Repair arterial blockage	6.03	NA	2.32	0.87	NA	9.22	000
35456	.....	A	Repair arterial blockage	7.34	NA	2.77	1.04	NA	11.15	000
35458	.....	A	Repair arterial blockage	9.48	NA	3.48	1.26	NA	14.22	000
35459	.....	A	Repair arterial blockage	8.62	NA	3.18	1.21	NA	13.01	000
35460	.....	A	Repair venous blockage	6.03	NA	2.28	0.83	NA	9.14	000
35470	.....	A	Repair arterial blockage	8.62	89.12	3.36	0.69	98.43	12.67	000
35471	.....	A	Repair arterial blockage	10.05	100.55	3.96	0.67	111.27	14.68	000
35472	.....	A	Repair arterial blockage	6.90	64.54	2.75	0.58	72.02	10.23	000
35473	.....	A	Repair arterial blockage	6.03	60.01	2.43	0.51	66.55	8.97	000
35474	.....	A	Repair arterial blockage	7.35	87.98	2.90	0.57	95.90	10.82	000
35475	.....	R	Repair arterial blockage	9.48	56.26	3.57	0.62	66.36	13.67	000
35476	.....	A	Repair venous blockage	6.03	44.86	2.36	0.34	51.23	8.73	000
35480	.....	A	Atherectomy, open	11.06	NA	4.05	1.28	NA	16.39	000
35481	.....	A	Atherectomy, open	7.60	NA	2.88	1.13	NA	11.61	000
35482	.....	A	Atherectomy, open	6.64	NA	2.57	0.89	NA	10.10	000
35483	.....	A	Atherectomy, open	8.09	NA	3.03	1.15	NA	12.27	000
35484	.....	A	Atherectomy, open	10.42	NA	3.78	1.27	NA	15.47	000
35485	.....	A	Atherectomy, open	9.48	NA	3.54	1.35	NA	14.37	000
35490	.....	A	Atherectomy, percutaneous	11.06	NA	4.71	0.71	NA	16.48	000
35491	.....	A	Atherectomy, percutaneous	7.60	NA	3.30	0.74	NA	11.64	000
35492	.....	A	Atherectomy, percutaneous	6.64	NA	3.20	0.43	NA	10.27	000
35493	.....	A	Atherectomy, percutaneous	8.09	NA	3.81	0.56	NA	12.46	000
35494	.....	A	Atherectomy, percutaneous	10.42	NA	4.47	0.59	NA	15.48	000
35495	.....	A	Atherectomy, percutaneous	9.48	NA	4.40	0.69	NA	14.57	000
35500	.....	A	Harvest vein for bypass	6.44	NA	2.03	0.93	NA	9.40	ZZZ
35501	.....	A	Artery bypass graft	19.16	NA	8.48	2.80	NA	30.44	090
35506	.....	A	Artery bypass graft	19.64	NA	9.49	2.86	NA	31.99	090
35507	.....	A	Artery bypass graft	19.64	NA	9.45	2.84	NA	31.93	090
35508	.....	A	Artery bypass graft	18.62	NA	9.47	2.77	NA	30.86	090
35509	.....	A	Artery bypass graft	18.04	NA	8.79	2.61	NA	29.44	090
35510	.....	A	Artery bypass graft	22.97	NA	10.20	2.11	NA	35.28	090
35511	.....	A	Artery bypass graft	21.17	NA	9.38	2.90	NA	33.45	090
35512	.....	A	Artery bypass graft	22.47	NA	10.03	2.11	NA	34.61	090
35515	.....	A	Artery bypass graft	18.62	NA	9.31	2.77	NA	30.70	090
35516	.....	A	Artery bypass graft	16.30	NA	6.82	2.33	NA	25.45	090
35518	.....	A	Artery bypass graft	21.17	NA	9.00	3.02	NA	33.19	090
35521	.....	A	Artery bypass graft	22.17	NA	9.86	3.12	NA	35.15	090
35522	.....	A	Artery bypass graft	21.73	NA	9.78	2.11	NA	33.62	090
35525	.....	A	Artery bypass graft	20.60	NA	9.40	2.11	NA	32.11	090
35526	.....	A	Artery bypass graft	29.91	NA	12.54	3.62	NA	46.07	090
35531	.....	A	Artery bypass graft	36.15	NA	14.51	5.16	NA	55.82	090
35533	.....	A	Artery bypass graft	27.96	NA	11.75	3.84	NA	43.55	090
35536	.....	A	Artery bypass graft	31.65	NA	12.98	4.61	NA	49.24	090
35541	.....	A	Artery bypass graft	25.76	NA	11.23	3.70	NA	40.69	090
35546	.....	A	Artery bypass graft	25.50	NA	10.89	3.69	NA	40.08	090
35548	.....	A	Artery bypass graft	21.54	NA	9.45	2.97	NA	33.96	090
35549	.....	A	Artery bypass graft	23.31	NA	10.40	3.29	NA	37.00	090
35551	.....	A	Artery bypass graft	26.63	NA	11.52	3.74	NA	41.89	090
35556	.....	A	Artery bypass graft	21.73	NA	9.75	3.09	NA	34.57	090
35558	.....	A	Artery bypass graft	21.17	NA	9.57	2.99	NA	33.73	090
35560	.....	A	Artery bypass graft	31.95	NA	13.35	4.74	NA	50.04	090
35563	.....	A	Artery bypass graft	24.16	NA	10.55	3.51	NA	38.22	090
35565	.....	A	Artery bypass graft	23.17	NA	10.16	3.29	NA	36.62	090
35566	.....	A	Artery bypass graft	26.88	NA	11.41	3.82	NA	42.11	090
35571	.....	A	Artery bypass graft	24.02	NA	10.87	3.42	NA	38.31	090
35572	.....	A	Harvest femoropopliteal vein	6.81	NA	2.25	0.99	NA	10.05	ZZZ
35583	.....	A	Vein bypass graft	22.34	NA	10.18	3.16	NA	35.68	090
35585	.....	A	Vein bypass graft	28.35	NA	12.25	4.01	NA	44.61	090
35587	.....	A	Vein bypass graft	24.71	NA	11.48	3.51	NA	39.70	090
35600	.....	A	Harvest artery for cabg	4.94	NA	1.62	0.73	NA	7.29	ZZZ
35601	.....	A	Artery bypass graft	17.47	NA	8.64	2.49	NA	28.60	090
35606	.....	A	Artery bypass graft	18.68	NA	9.04	2.69	NA	30.41	090
35612	.....	A	Artery bypass graft	15.74	NA	7.90	2.08	NA	25.72	090
35616	.....	A	Artery bypass graft	15.68	NA	8.12	2.19	NA	25.99	090
35621	.....	A	Artery bypass graft	19.97	NA	8.70	2.91	NA	31.58	090
35623	.....	A	Bypass graft, not vein	23.96	NA	10.52	3.45	NA	37.93	090
35626	.....	A	Artery bypass graft	27.71	NA	12.00	4.07	NA	43.78	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
35631	.....	A	Artery bypass graft	33.95	NA	13.87	4.95	NA	52.77	090
35636	.....	A	Artery bypass graft	29.46	NA	12.33	4.09	NA	45.88	090
35641	.....	A	Artery bypass graft	24.53	NA	11.09	3.53	NA	39.15	090
35642	.....	A	Artery bypass graft	17.95	NA	8.71	2.27	NA	28.93	090
35645	.....	A	Artery bypass graft	17.44	NA	8.29	2.49	NA	28.22	090
35646	.....	A	Artery bypass graft	30.95	NA	13.14	4.43	NA	48.52	090
35647	.....	A	Artery bypass graft	27.96	NA	11.80	3.98	NA	43.74	090
35650	.....	A	Artery bypass graft	18.97	NA	8.38	2.71	NA	30.06	090
35651	.....	A	Artery bypass graft	25.00	NA	10.75	3.35	NA	39.10	090
35654	.....	A	Artery bypass graft	24.96	NA	10.68	3.52	NA	39.16	090
35656	.....	A	Artery bypass graft	19.50	NA	8.62	2.79	NA	30.91	090
35661	.....	A	Artery bypass graft	18.97	NA	8.95	2.71	NA	30.63	090
35663	.....	A	Artery bypass graft	21.97	NA	10.00	3.10	NA	35.07	090
35665	.....	A	Artery bypass graft	20.97	NA	9.47	3.00	NA	33.44	090
35666	.....	A	Artery bypass graft	22.16	NA	10.67	3.15	NA	35.98	090
35671	.....	A	Artery bypass graft	19.30	NA	9.39	2.77	NA	31.46	090
35681	.....	A	Composite bypass graft	1.60	NA	0.53	0.23	NA	2.36	ZZZ
35682	.....	A	Composite bypass graft	7.19	NA	2.39	1.03	NA	10.61	ZZZ
35683	.....	A	Composite bypass graft	8.49	NA	2.83	1.20	NA	12.52	ZZZ
35685	.....	A	Bypass graft patency/patch	4.04	NA	1.35	0.58	NA	5.97	ZZZ
35686	.....	A	Bypass graft/av fist patency	3.34	NA	1.13	0.47	NA	4.94	ZZZ
35691	.....	A	Arterial transposition	18.02	NA	8.42	2.58	NA	29.02	090
35693	.....	A	Arterial transposition	15.34	NA	7.74	2.21	NA	25.29	090
35694	.....	A	Arterial transposition	19.13	NA	8.62	2.69	NA	30.44	090
35695	.....	A	Arterial transposition	19.13	NA	8.57	2.73	NA	30.43	090
35697	.....	A	Reimplant artery each	3.00	NA	1.02	0.41	NA	4.43	ZZZ
35700	.....	A	Reoperation, bypass graft	3.08	NA	1.02	0.44	NA	4.54	ZZZ
35701	.....	A	Exploration, carotid artery	8.49	NA	5.16	1.12	NA	14.77	090
35721	.....	A	Exploration, femoral artery	7.17	NA	4.44	1.03	NA	12.64	090
35741	.....	A	Exploration popliteal artery	7.99	NA	4.67	1.12	NA	13.78	090
35761	.....	A	Exploration of artery/vein	5.36	NA	4.02	0.75	NA	10.13	090
35800	.....	A	Explore neck vessels	7.01	NA	4.66	0.95	NA	12.62	090
35820	.....	A	Explore chest vessels	12.86	NA	7.22	1.94	NA	22.02	090
35840	.....	A	Explore abdominal vessels	9.76	NA	5.30	1.34	NA	16.40	090
35860	.....	A	Explore limb vessels	5.54	NA	4.04	0.78	NA	10.36	090
35870	.....	A	Repair vessel graft defect	22.14	NA	9.79	3.00	NA	34.93	090
35875	.....	A	Removal of clot in graft	10.11	NA	5.20	1.41	NA	16.72	090
35876	.....	A	Removal of clot in graft	16.97	NA	7.53	2.39	NA	26.89	090
35879	.....	A	Revise graft w/vein	15.98	NA	7.71	2.27	NA	25.96	090
35881	.....	A	Revise graft w/vein	17.97	NA	8.69	2.55	NA	29.21	090
35901	.....	A	Excision, graft, neck	8.18	NA	5.32	1.15	NA	14.65	090
35903	.....	A	Excision, graft, extremity	9.38	NA	6.17	1.30	NA	16.85	090
35905	.....	A	Excision, graft, thorax	31.20	NA	13.22	4.43	NA	48.85	090
35907	.....	A	Excision, graft, abdomen	34.95	NA	14.20	4.91	NA	54.06	090
36000	.....	A	Place needle in vein	0.18	0.57	0.05	0.01	0.76	0.24	XXX
36002	.....	A	Pseudoaneurysm injection trt	1.96	2.87	0.97	0.17	5.00	3.10	000
36005	.....	A	Injection ext venography	0.95	7.67	0.31	0.05	8.67	1.31	000
36010	.....	A	Place catheter in vein	2.43	19.36	0.79	0.20	21.99	3.42	XXX
36011	.....	A	Place catheter in vein	3.14	27.90	1.06	0.27	31.31	4.47	XXX
36012	.....	A	Place catheter in vein	3.51	19.00	1.19	0.23	22.74	4.93	XXX
36013	.....	A	Place catheter in artery	2.52	21.42	0.69	0.25	24.19	3.46	XXX
36014	.....	A	Place catheter in artery	3.02	20.18	1.03	0.19	23.39	4.24	XXX
36015	.....	A	Place catheter in artery	3.51	23.73	1.19	0.21	27.45	4.91	XXX
36100	.....	A	Establish access to artery	3.02	12.11	1.11	0.26	15.39	4.39	XXX
36120	.....	A	Establish access to artery	2.01	10.73	0.65	0.14	12.88	2.80	XXX
36140	.....	A	Establish access to artery	2.01	12.81	0.64	0.16	14.98	2.81	XXX
36145	.....	A	Artery to vein shunt	2.01	12.59	0.66	0.11	14.71	2.78	XXX
36160	.....	A	Establish access to aorta	2.52	13.52	0.84	0.26	16.30	3.62	XXX
36200	.....	A	Place catheter in aorta	3.02	16.56	1.01	0.24	19.82	4.27	XXX
36215	.....	A	Place catheter in artery	4.67	27.11	1.61	0.27	32.05	6.55	XXX
36216	.....	A	Place catheter in artery	5.27	29.16	1.80	0.31	34.74	7.38	XXX
36217	.....	A	Place catheter in artery	6.29	55.60	2.18	0.44	62.33	8.91	XXX
36218	.....	A	Place catheter in artery	1.01	5.10	0.34	0.07	6.18	1.42	ZZZ
36245	.....	A	Place catheter in artery	4.67	32.18	1.68	0.31	37.16	6.66	XXX
36246	.....	A	Place catheter in artery	5.27	30.05	1.83	0.38	35.70	7.48	XXX
36247	.....	A	Place catheter in artery	6.29	49.65	2.15	0.47	56.41	8.91	XXX
36248	.....	A	Place catheter in artery	1.01	4.05	0.34	0.07	5.13	1.42	ZZZ
36260	.....	A	Insertion of infusion pump	9.70	NA	4.89	1.29	NA	15.88	090
36261	.....	A	Revision of infusion pump	5.44	NA	3.67	0.70	NA	9.81	090
36262	.....	A	Removal of infusion pump	4.01	NA	2.76	0.54	NA	7.31	090
36299	.....	C	Vessel injection procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
36400	.....	A	Bl draw < 3 yrs fem/jugular	0.38	0.28	0.09	0.03	0.69	0.50	XXX
36405	.....	A	Bl draw < 3 yrs scalp vein	0.31	0.26	0.08	0.03	0.60	0.42	XXX
36406	.....	A	Bl draw < 3 yrs other vein	0.18	0.28	0.05	0.01	0.47	0.24	XXX
36410	.....	A	Non-routine bl draw > 3 yrs	0.18	0.29	0.05	0.01	0.48	0.24	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
36415	.....	X	Routine venipuncture	0.00	0.00	0.00	0.00	0.00	0.00	XXX
36416	.....	B	Capillary blood draw	0.00	0.00	0.00	0.00	0.00	0.00	XXX
36420	.....	A	Vein access cutdown < 1 yr	1.01	0.34	0.27	0.07	1.42	1.35	XXX
36425	.....	A	Vein access cutdown > 1 yr	0.76	NA	0.22	0.06	NA	1.04	XXX
36430	.....	A	Blood transfusion service	0.00	1.01	NA	0.06	1.07	NA	XXX
36440	.....	A	Bl push transfuse, 2 yr or <	1.03	NA	0.29	0.10	NA	1.42	XXX
36450	.....	A	Bl exchange/transfuse, nb	2.23	NA	0.71	0.21	NA	3.15	XXX
36455	.....	A	Bl exchange/transfuse non-nb	2.43	NA	1.01	0.15	NA	3.59	XXX
36460	.....	A	Transfusion service, fetal	6.58	NA	2.25	0.79	NA	9.62	XXX
36468	.....	R	Injection(s), spider veins	0.00	0.00	0.00	0.00	0.00	0.00	000
36469	.....	R	Injection(s), spider veins	0.00	0.00	0.00	0.00	0.00	0.00	000
36470	.....	A	Injection therapy of vein	1.09	2.69	0.73	0.12	3.90	1.94	010
36471	.....	A	Injection therapy of veins	1.57	3.08	0.96	0.19	4.84	2.72	010
36475	.....	A	Endovenous rf, 1st vein	6.72	51.54	2.54	0.37	58.63	9.63	000
36476	.....	A	Endovenous rf, vein add-on	3.38	7.90	1.14	0.18	11.46	4.70	ZZZ
36478	.....	A	Endovenous laser, 1st vein	6.72	46.91	2.54	0.37	54.00	9.63	000
36479	.....	A	Endovenous laser vein addon	3.38	8.01	1.14	0.18	11.57	4.70	ZZZ
36481	.....	A	Insertion of catheter, vein	6.98	5.75	2.60	0.55	13.28	10.13	000
36500	.....	A	Insertion of catheter, vein	3.51	NA	1.37	0.20	NA	5.08	000
36510	.....	A	Insertion of catheter, vein	1.09	3.90	0.61	0.10	5.09	1.80	000
36511	.....	A	Apheresis wbc	1.74	NA	0.73	0.08	NA	2.55	000
36512	.....	A	Apheresis rbc	1.74	NA	0.74	0.08	NA	2.56	000
36513	.....	A	Apheresis platelets	1.74	NA	0.73	0.17	NA	2.64	000
36514	.....	A	Apheresis plasma	1.74	17.02	0.71	0.08	18.84	2.53	000
36515	.....	A	Apheresis, adsorp/reinfuse	1.74	66.49	0.66	0.08	68.31	2.48	000
36516	.....	A	Apheresis, selective	1.22	84.29	0.48	0.08	85.59	1.78	000
36522	.....	A	Photopheresis	1.67	32.46	0.96	0.13	34.26	2.76	000
36540	.....	B	Collect blood venous device	0.00	0.00	0.00	0.00	0.00	0.00	XXX
36550	.....	A	Declot vascular device	0.00	0.39	NA	0.37	0.76	NA	XXX
36555	.....	A	Insert non-tunnel cv cath	2.68	5.77	0.80	0.11	8.56	3.59	000
36556	.....	A	Insert non-tunnel cv cath	2.50	5.64	0.74	0.19	8.33	3.43	000
36557	.....	A	Insert tunneled cv cath	5.09	21.20	2.66	0.57	26.86	8.32	010
36558	.....	A	Insert tunneled cv cath	4.79	21.10	2.56	0.57	26.46	7.92	010
36560	.....	A	Insert tunneled cv cath	6.24	29.76	3.04	0.57	36.57	9.85	010
36561	.....	A	Insert tunneled cv cath	5.99	29.67	2.96	0.57	36.23	9.52	010
36563	.....	A	Insert tunneled cv cath	6.19	26.82	2.99	0.84	33.85	10.02	010
36565	.....	A	Insert tunneled cv cath	5.99	24.77	2.96	0.57	31.33	9.52	010
36566	.....	A	Insert tunneled cv cath	6.49	25.57	3.12	0.57	32.63	10.18	010
36568	.....	A	Insert picc cath	1.92	7.55	0.58	0.11	9.58	2.61	000
36569	.....	A	Insert picc cath	1.82	7.36	0.57	0.19	9.37	2.58	000
36570	.....	A	Insert picvad cath	5.31	33.27	2.73	0.57	39.15	8.61	010
36571	.....	A	Insert picvad cath	5.29	33.34	2.72	0.57	39.20	8.58	010
36575	.....	A	Repair tunneled cv cath	0.67	4.06	0.26	0.20	4.93	1.13	000
36576	.....	A	Repair tunneled cv cath	3.19	6.96	1.85	0.19	10.34	5.23	010
36578	.....	A	Replace tunneled cv cath	3.49	11.16	2.31	0.19	14.84	5.99	010
36580	.....	A	Replace cvad cath	1.31	6.96	0.41	0.19	8.46	1.91	000
36581	.....	A	Replace tunneled cv cath	3.43	19.55	1.93	0.19	23.17	5.55	010
36582	.....	A	Replace tunneled cv cath	5.19	26.09	2.87	0.19	31.47	8.25	010
36583	.....	A	Replace tunneled cv cath	5.24	26.11	2.89	0.19	31.54	8.32	010
36584	.....	A	Replace picc cath	1.20	6.99	0.55	0.19	8.38	1.94	000
36585	.....	A	Replace picvad cath	4.79	27.90	2.74	0.19	32.88	7.72	010
36589	.....	A	Removal tunneled cv cath	2.27	2.25	1.39	0.24	4.76	3.90	010
36590	.....	A	Removal tunneled cv cath	3.30	3.38	1.72	0.44	7.12	5.46	010
36595	.....	A	Mech remov tunneled cv cath	3.59	17.30	1.45	0.21	21.10	5.25	000
36596	.....	A	Mech remov tunneled cv cath	0.75	3.70	0.50	0.05	4.50	1.30	000
36597	.....	A	Reposition venous catheter	1.21	2.41	0.44	0.07	3.69	1.72	000
36598	.....	T	Inj w/fluor, eval cv device	0.74	2.65	2.65	0.05	3.44	3.44	000
36600	.....	A	Withdrawal of arterial blood	0.32	0.49	0.09	0.02	0.83	0.43	XXX
36620	.....	A	Insertion catheter, artery	1.15	NA	0.23	0.07	NA	1.45	000
36625	.....	A	Insertion catheter, artery	2.11	NA	0.53	0.26	NA	2.90	000
36640	.....	A	Insertion catheter, artery	2.10	NA	1.04	0.21	NA	3.35	000
36660	.....	A	Insertion catheter, artery	1.40	NA	0.44	0.14	NA	1.98	000
36680	.....	A	Insert needle, bone cavity	1.20	NA	0.49	0.11	NA	1.80	000
36800	.....	A	Insertion of cannula	2.43	NA	1.81	0.25	NA	4.49	000
36810	.....	A	Insertion of cannula	3.96	NA	1.68	0.45	NA	6.09	000
36815	.....	A	Insertion of cannula	2.62	NA	1.17	0.35	NA	4.14	000
36818	.....	A	Av fuse, uppr arm, cephalic	11.52	NA	6.05	1.89	NA	19.46	090
36819	.....	A	Av fuse, uppr arm, basilic	13.98	NA	6.39	1.95	NA	22.32	090
36820	.....	A	Av fusion/forearm vein	13.98	NA	6.40	1.94	NA	22.32	090
36821	.....	A	Av fusion direct any site	8.92	NA	4.66	1.23	NA	14.81	090
36822	.....	A	Insertion of cannula(s)	5.41	NA	4.39	0.79	NA	10.59	090
36823	.....	A	Insertion of cannula(s)	20.97	NA	9.40	2.88	NA	33.25	090
36825	.....	A	Artery-vein autograft	9.83	NA	5.06	1.35	NA	16.24	090
36830	.....	A	Artery-vein nonautograft	11.98	NA	5.25	1.66	NA	18.89	090
36831	.....	A	Open thrombect av fistula	7.99	NA	3.95	1.09	NA	13.03	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
36832	.....	A	Av fistula revision, open	10.48	NA	4.73	1.44	NA	16.65	090
36833	.....	A	Av fistula revision	11.93	NA	5.22	1.65	NA	18.80	090
36834	.....	A	Repair A-V aneurysm	9.92	NA	4.80	1.37	NA	16.09	090
36835	.....	A	Artery to vein shunt	7.14	NA	4.33	0.98	NA	12.45	090
36838	.....	A	Dist revas ligation, hemo	20.60	NA	9.41	3.01	NA	33.02	090
36860	.....	A	External cannula declotting	2.01	1.78	0.68	0.11	3.90	2.80	000
36861	.....	A	Cannula declotting	2.52	NA	1.49	0.27	NA	4.28	000
36870	.....	A	Percut thrombect av fistula	5.15	53.18	3.16	0.29	58.62	8.60	090
37140	.....	A	Revision of circulation	23.56	NA	10.51	2.01	NA	36.08	090
37145	.....	A	Revision of circulation	24.57	NA	10.89	3.25	NA	38.71	090
37160	.....	A	Revision of circulation	21.57	NA	9.28	2.81	NA	33.66	090
37180	.....	A	Revision of circulation	24.57	NA	10.32	3.34	NA	38.23	090
37181	.....	A	Splice spleen/kidney veins	26.64	NA	11.03	3.40	NA	41.07	090
37182	.....	A	Insert hepatic shunt (tips)	16.97	NA	6.08	1.00	NA	24.05	000
37183	.....	A	Remove hepatic shunt (tips)	7.99	NA	3.02	0.47	NA	11.48	000
37184	.....	A	Prim art mech thrombectomy	8.66	71.90	3.36	0.55	81.11	12.57	000
37185	.....	A	Prim art m-thrombect add-on	3.28	22.95	1.11	0.21	26.44	4.60	ZZZ
37186	.....	A	Sec art m-thrombect add-on	4.92	49.53	1.66	0.32	54.77	6.90	ZZZ
37187	.....	A	Venous mech thrombectomy	8.03	70.38	3.15	0.51	78.92	11.69	000
37188	.....	A	Venous m-thrombectomy add-on	5.71	62.15	2.37	0.37	68.23	8.45	000
37195	.....	C	Thrombolytic therapy, stroke	0.00	0.00	0.00	0.00	0.00	0.00	XXX
37200	.....	A	Transcatheter biopsy	4.55	NA	1.50	0.27	NA	6.32	000
37201	.....	A	Transcatheter therapy infuse	4.99	NA	2.55	0.33	NA	7.87	000
37202	.....	A	Transcatheter therapy infuse	5.67	NA	3.04	0.43	NA	9.14	000
37203	.....	A	Transcatheter retrieval	5.02	32.97	2.04	0.29	38.28	7.35	000
37204	.....	A	Transcatheter occlusion	18.11	NA	5.92	1.48	NA	25.51	000
37205	.....	A	Transcath iv stent, percut	8.27	NA	3.76	0.60	NA	12.63	000
37206	.....	A	Transcath iv stent/perc addl	4.12	NA	1.43	0.31	NA	5.86	ZZZ
37207	.....	A	Transcath iv stent, open	8.27	NA	3.17	1.17	NA	12.61	000
37208	.....	A	Transcath iv stent/open addl	4.12	NA	1.38	0.59	NA	6.09	ZZZ
37209	.....	A	Change iv cath at thromb tx	2.27	NA	0.74	0.15	NA	3.16	000
37215	.....	R	Transcath stent, cca w/eps	18.71	NA	9.12	1.09	NA	28.92	090
37216	.....	R	Transcath stent, cca w/o eps	17.98	NA	8.84	1.04	NA	27.86	090
37250	.....	A	Iv us first vessel add-on	2.10	NA	0.75	0.21	NA	3.06	ZZZ
37251	.....	A	Iv us each add vessel add-on	1.60	NA	0.55	0.19	NA	2.34	ZZZ
37500	.....	A	Endoscopy ligate perf veins	10.98	NA	6.87	1.54	NA	19.39	090
37501	.....	C	Vascular endoscopy procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
37565	.....	A	Ligation of neck vein	10.86	NA	5.64	1.33	NA	17.83	090
37600	.....	A	Ligation of neck artery	11.23	NA	6.65	1.41	NA	19.29	090
37605	.....	A	Ligation of neck artery	13.09	NA	6.92	1.98	NA	21.99	090
37606	.....	A	Ligation of neck artery	6.27	NA	4.57	1.23	NA	12.07	090
37607	.....	A	Ligation of a-v fistula	6.15	NA	3.57	0.85	NA	10.57	090
37609	.....	A	Temporal artery procedure	3.00	4.51	1.97	0.36	7.87	5.33	010
37615	.....	A	Ligation of neck artery	5.72	NA	4.12	0.68	NA	10.52	090
37616	.....	A	Ligation of chest artery	16.47	NA	8.10	2.32	NA	26.89	090
37617	.....	A	Ligation of abdomen artery	22.03	NA	9.20	2.97	NA	34.20	090
37618	.....	A	Ligation of extremity artery	4.83	NA	3.62	0.67	NA	9.12	090
37620	.....	A	Revision of major vein	10.54	NA	5.73	0.91	NA	17.18	090
37650	.....	A	Revision of major vein	7.79	NA	4.69	1.01	NA	13.49	090
37660	.....	A	Revision of major vein	20.97	NA	9.08	2.48	NA	32.53	090
37700	.....	A	Revise leg vein	3.72	NA	2.80	0.53	NA	7.05	090
37718	.....	A	Ligate/strip short leg vein	6.76	NA	4.07	0.14	NA	10.97	090
37722	.....	A	Ligate/strip long leg vein	7.79	NA	4.42	0.86	NA	13.07	090
37735	.....	A	Removal of leg veins/lesion	10.51	NA	5.52	1.48	NA	17.51	090
37760	.....	A	Ligation, leg veins, open	10.45	NA	5.36	1.44	NA	17.25	090
37765	.....	A	Phleb veins - extrem - to 20	7.34	NA	4.63	0.48	NA	12.45	090
37766	.....	A	Phleb veins - extrem 20+	9.29	NA	5.34	0.48	NA	15.11	090
37780	.....	A	Revision of leg vein	3.83	NA	2.86	0.53	NA	7.22	090
37785	.....	A	Ligate/divide/excise vein	3.83	5.21	2.73	0.54	9.58	7.10	090
37788	.....	A	Revascularization, penis	21.98	NA	9.11	2.25	NA	33.34	090
37790	.....	A	Penile venous occlusion	8.33	NA	4.38	0.59	NA	13.30	090
37799	.....	C	Vascular surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
38100	.....	A	Removal of spleen, total	14.48	NA	6.19	1.91	NA	22.58	090
38101	.....	A	Removal of spleen, partial	15.29	NA	6.54	2.04	NA	23.87	090
38102	.....	A	Removal of spleen, total	4.79	NA	1.64	0.63	NA	7.06	ZZZ
38115	.....	A	Repair of ruptured spleen	15.80	NA	6.66	2.08	NA	24.54	090
38120	.....	A	Laparoscopy, splenectomy	16.97	NA	7.40	2.24	NA	26.61	090
38129	.....	C	Laparoscope proc, spleen	0.00	0.00	0.00	0.00	0.00	0.00	YYY
38200	.....	A	Injection for spleen x-ray	2.64	NA	0.89	0.14	NA	3.67	000
38204	.....	B	Bl donor search management	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38205	.....	R	Harvest allogenic stem cells	1.50	NA	0.67	0.07	NA	2.24	000
38206	.....	R	Harvest auto stem cells	1.50	NA	0.67	0.07	NA	2.24	000
38207	.....	I	Cryopreserve stem cells	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38208	.....	I	Thaw preserved stem cells	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38209	.....	I	Wash harvest stem cells	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
38210	.....	I	T-cell depletion of harvest	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38211	.....	I	Tumor cell deplete of harvst	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38212	.....	I	Rbc depletion of harvest	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38213	.....	I	Platelet deplete of harvest	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38214	.....	I	Volume deplete of harvest	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38215	.....	I	Harvest stem cell concentrte	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38220	.....	A	Bone marrow aspiration	1.08	3.73	0.52	0.05	4.86	1.65	XXX
38221	.....	A	Bone marrow biopsy	1.37	3.94	0.65	0.07	5.38	2.09	XXX
38230	.....	R	Bone marrow collection	4.53	NA	3.23	0.48	NA	8.24	010
38240	.....	R	Bone marrow/stem transplant	2.24	NA	1.03	0.11	NA	3.38	XXX
38241	.....	R	Bone marrow/stem transplant	2.24	NA	1.04	0.11	NA	3.39	XXX
38242	.....	A	Lymphocyte infuse transplant	1.71	NA	0.78	0.08	NA	2.57	000
38300	.....	A	Drainage, lymph node lesion	1.99	4.31	2.06	0.25	6.55	4.30	010
38305	.....	A	Drainage, lymph node lesion	5.99	NA	4.45	0.88	NA	11.32	090
38308	.....	A	Incision of lymph channels	6.44	NA	3.75	0.85	NA	11.04	090
38380	.....	A	Thoracic duct procedure	7.45	NA	5.70	0.74	NA	13.89	090
38381	.....	A	Thoracic duct procedure	12.86	NA	6.90	1.84	NA	21.60	090
38382	.....	A	Thoracic duct procedure	10.06	NA	5.77	1.37	NA	17.20	090
38500	.....	A	Biopsy/removal, lymph nodes	3.74	3.70	2.09	0.49	7.93	6.32	010
38505	.....	A	Needle biopsy, lymph nodes	1.14	2.06	0.78	0.09	3.29	2.01	000
38510	.....	A	Biopsy/removal, lymph nodes	6.42	5.56	3.49	0.72	12.70	10.63	010
38520	.....	A	Biopsy/removal, lymph nodes	6.66	NA	4.06	0.84	NA	11.56	090
38525	.....	A	Biopsy/removal, lymph nodes	6.06	NA	3.30	0.80	NA	10.16	090
38530	.....	A	Biopsy/removal, lymph nodes	7.97	NA	4.40	1.12	NA	13.49	090
38542	.....	A	Explore deep node(s), neck	5.90	NA	4.49	0.60	NA	10.99	090
38550	.....	A	Removal, neck/armpit lesion	6.91	NA	3.92	0.88	NA	11.71	090
38555	.....	A	Removal, neck/armpit lesion	14.12	NA	8.55	1.75	NA	24.42	090
38562	.....	A	Removal, pelvic lymph nodes	10.47	NA	5.79	1.20	NA	17.46	090
38564	.....	A	Removal, abdomen lymph nodes	10.81	NA	5.26	1.32	NA	17.39	090
38570	.....	A	Laparoscopy, lymph node biop	9.24	NA	3.98	1.13	NA	14.35	010
38571	.....	A	Laparoscopy, lymphadenectomy	14.66	NA	5.66	1.15	NA	21.47	010
38572	.....	A	Laparoscopy, lymphadenectomy	16.57	NA	7.09	1.90	NA	25.56	010
38589	.....	C	Laparoscope proc, lymphatic	0.00	0.00	0.00	0.00	0.00	0.00	YYY
38700	.....	A	Removal of lymph nodes, neck	8.23	NA	6.25	0.72	NA	15.20	090
38720	.....	A	Removal of lymph nodes, neck	13.59	NA	9.38	1.20	NA	24.17	090
38724	.....	A	Removal of lymph nodes, neck	14.52	NA	9.86	1.28	NA	25.66	090
38740	.....	A	Remove armpit lymph nodes	10.01	NA	4.95	1.32	NA	16.28	090
38745	.....	A	Remove armpit lymph nodes	13.08	NA	6.09	1.73	NA	20.90	090
38746	.....	A	Remove thoracic lymph nodes	4.88	NA	1.61	0.72	NA	7.21	ZZZ
38747	.....	A	Remove abdominal lymph nodes	4.88	NA	1.67	0.64	NA	7.19	ZZZ
38760	.....	A	Remove groin lymph nodes	12.93	NA	6.14	1.71	NA	20.78	090
38765	.....	A	Remove groin lymph nodes	19.95	NA	8.83	2.47	NA	31.25	090
38770	.....	A	Remove pelvis lymph nodes	13.21	NA	5.76	1.40	NA	20.37	090
38780	.....	A	Remove abdomen lymph nodes	16.57	NA	8.22	1.88	NA	26.67	090
38790	.....	A	Inject for lymphatic x-ray	1.29	7.37	0.76	0.13	8.79	2.18	000
38792	.....	A	Identify sentinel node	0.52	NA	0.44	0.06	NA	1.02	000
38794	.....	A	Access thoracic lymph duct	4.44	NA	3.46	0.32	NA	8.22	090
38999	.....	C	Blood/lymph system procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
39000	.....	A	Exploration of chest	6.09	NA	4.66	0.89	NA	11.64	090
39010	.....	A	Exploration of chest	11.77	NA	7.56	1.75	NA	21.08	090
39200	.....	A	Removal chest lesion	13.60	NA	7.55	2.02	NA	23.17	090
39220	.....	A	Removal chest lesion	17.39	NA	9.39	2.45	NA	29.23	090
39400	.....	A	Visualization of chest	5.60	NA	4.86	0.82	NA	11.28	010
39499	.....	C	Chest procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
39501	.....	A	Repair diaphragm laceration	13.17	NA	6.47	1.77	NA	21.41	090
39502	.....	A	Repair paraesophageal hernia	16.31	NA	7.16	2.16	NA	25.63	090
39503	.....	A	Repair of diaphragm hernia	94.86	NA	33.47	10.95	NA	139.28	090
39520	.....	A	Repair of diaphragm hernia	16.08	NA	8.06	2.23	NA	26.37	090
39530	.....	A	Repair of diaphragm hernia	15.39	NA	7.15	2.10	NA	24.64	090
39531	.....	A	Repair of diaphragm hernia	16.40	NA	7.40	2.21	NA	26.01	090
39540	.....	A	Repair of diaphragm hernia	13.30	NA	6.24	1.79	NA	21.33	090
39541	.....	A	Repair of diaphragm hernia	14.39	NA	6.60	1.92	NA	22.91	090
39545	.....	A	Revision of diaphragm	13.35	NA	7.56	1.83	NA	22.74	090
39560	.....	A	Resect diaphragm, simple	11.98	NA	6.30	1.59	NA	19.87	090
39561	.....	A	Resect diaphragm, complex	17.47	NA	9.36	2.44	NA	29.27	090
39599	.....	C	Diaphragm surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
4000F	.....	I	Tobacco use txmnt counseling	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4001F	.....	I	Tobacco use txmnt, pharmacol	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4002F	.....	I	Statin therapy, rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4003F	.....	I	Pt ed write/oral, pts w/ hf	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4006F	.....	I	Beta-blocker therapy rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4009F	.....	I	Ace inhibitor therapy rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4011F	.....	I	Oral antiplatelet therapy rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4012F	.....	I	Warfarin therapy rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4014F	.....	I	Written discharge instr prvd	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
4015F		I	Persist asthma medicine ctrl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4016F		I	Anti-inflm/anlgsc agent rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4017F		I	Gi prophylaxis for nsaid rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4018F		I	Therapy exercise joint rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
40490		A	Biopsy of lip	1.22	1.63	0.61	0.05	2.90	1.88	000
40500		A	Partial excision of lip	4.27	6.91	4.34	0.38	11.56	8.99	090
40510		A	Partial excision of lip	4.69	6.63	4.02	0.49	11.81	9.20	090
40520		A	Partial excision of lip	4.66	7.56	4.12	0.52	12.74	9.30	090
40525		A	Reconstruct lip with flap	7.54	NA	6.32	0.85	NA	14.71	090
40527		A	Reconstruct lip with flap	9.12	NA	7.37	0.97	NA	17.46	090
40530		A	Partial removal of lip	5.39	7.83	4.59	0.55	13.77	10.53	090
40650		A	Repair lip	3.63	6.81	3.30	0.38	10.82	7.31	090
40652		A	Repair lip	4.25	7.76	4.27	0.52	12.53	9.04	090
40654		A	Repair lip	5.30	8.62	4.94	0.60	14.52	10.84	090
40700		A	Repair cleft lip/nasal	12.77	NA	9.10	0.95	NA	22.82	090
40701		A	Repair cleft lip/nasal	15.83	NA	11.36	1.65	NA	28.84	090
40702		A	Repair cleft lip/nasal	13.02	NA	8.27	1.23	NA	22.52	090
40720		A	Repair cleft lip/nasal	13.53	NA	9.92	1.79	NA	25.24	090
40761		A	Repair cleft lip/nasal	14.70	NA	10.30	1.93	NA	26.93	090
40799		C	Lip surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
40800		A	Drainage of mouth lesion	1.17	2.97	1.78	0.13	4.27	3.08	010
40801		A	Drainage of mouth lesion	2.53	4.03	2.75	0.31	6.87	5.59	010
40804		A	Removal, foreign body, mouth	1.24	3.40	1.86	0.11	4.75	3.21	010
40805		A	Removal, foreign body, mouth	2.69	4.49	2.82	0.32	7.50	5.83	010
40806		A	Incision of lip fold	0.31	1.84	0.50	0.04	2.19	0.85	000
40808		A	Biopsy of mouth lesion	0.96	2.66	1.48	0.10	3.72	2.54	010
40810		A	Excision of mouth lesion	1.31	2.89	1.66	0.13	4.33	3.10	010
40812		A	Excise/repair mouth lesion	2.31	3.73	2.41	0.28	6.32	5.00	010
40814		A	Excise/repair mouth lesion	3.41	4.95	3.90	0.41	8.77	7.72	090
40816		A	Excision of mouth lesion	3.66	5.18	4.01	0.40	9.24	8.07	090
40818		A	Excise oral mucosa for graft	2.41	5.18	3.98	0.21	7.80	6.60	090
40819		A	Excise lip or cheek fold	2.41	4.09	3.10	0.29	6.79	5.80	090
40820		A	Treatment of mouth lesion	1.28	3.94	2.45	0.11	5.33	3.84	010
40830		A	Repair mouth laceration	1.76	3.73	2.10	0.19	5.68	4.05	010
40831		A	Repair mouth laceration	2.46	4.67	3.06	0.30	7.43	5.82	010
40840		R	Reconstruction of mouth	8.72	9.81	6.99	1.08	19.61	16.79	090
40842		R	Reconstruction of mouth	8.72	10.09	6.80	1.08	19.89	16.60	090
40843		R	Reconstruction of mouth	12.08	11.98	7.83	1.39	25.45	21.30	090
40844		R	Reconstruction of mouth	15.99	15.81	11.59	1.99	33.79	29.57	090
40845		R	Reconstruction of mouth	18.55	17.11	13.25	2.00	37.66	33.80	090
40899		C	Mouth surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
41000		A	Drainage of mouth lesion	1.30	2.32	1.41	0.12	3.74	2.83	010
41005		A	Drainage of mouth lesion	1.26	3.34	1.72	0.12	4.72	3.10	010
41006		A	Drainage of mouth lesion	3.24	4.80	3.18	0.35	8.39	6.77	090
41007		A	Drainage of mouth lesion	3.10	5.15	3.03	0.31	8.56	6.44	090
41008		A	Drainage of mouth lesion	3.36	4.69	3.21	0.42	8.47	6.99	090
41009		A	Drainage of mouth lesion	3.58	4.98	3.58	0.47	9.03	7.63	090
41010		A	Incision of tongue fold	1.06	3.43	1.60	0.07	4.56	2.73	010
41015		A	Drainage of mouth lesion	3.95	5.42	4.15	0.46	9.83	8.56	090
41016		A	Drainage of mouth lesion	4.06	5.63	4.23	0.53	10.22	8.82	090
41017		A	Drainage of mouth lesion	4.06	5.65	4.31	0.53	10.24	8.90	090
41018		A	Drainage of mouth lesion	5.09	6.15	4.58	0.68	11.92	10.35	090
41100		A	Biopsy of tongue	1.63	2.43	1.42	0.15	4.21	3.20	010
41105		A	Biopsy of tongue	1.42	2.31	1.32	0.13	3.86	2.87	010
41108		A	Biopsy of floor of mouth	1.05	2.08	1.13	0.10	3.23	2.28	010
41110		A	Excision of tongue lesion	1.51	2.99	1.64	0.13	4.63	3.28	010
41112		A	Excision of tongue lesion	2.73	4.48	3.23	0.28	7.49	6.24	090
41113		A	Excision of tongue lesion	3.19	4.75	3.48	0.34	8.28	7.01	090
41114		A	Excision of tongue lesion	8.46	NA	7.21	0.83	NA	16.50	090
41115		A	Excision of tongue fold	1.74	3.30	1.86	0.18	5.22	3.78	010
41116		A	Excision of mouth lesion	2.44	4.36	2.81	0.23	7.03	5.48	090
41120		A	Partial removal of tongue	9.76	NA	15.35	0.79	NA	25.90	090
41130		A	Partial removal of tongue	11.13	NA	16.24	0.93	NA	28.30	090
41135		A	Tongue and neck surgery	23.06	NA	23.29	1.88	NA	48.23	090
41140		A	Removal of tongue	25.46	NA	26.75	2.26	NA	54.47	090
41145		A	Tongue removal, neck surgery	30.01	NA	30.63	2.54	NA	63.18	090
41150		A	Tongue, mouth, jaw surgery	23.01	NA	24.78	1.94	NA	49.73	090
41153		A	Tongue, mouth, neck surgery	23.73	NA	25.09	2.00	NA	50.82	090
41155		A	Tongue, jaw, & neck surgery	27.68	NA	26.88	2.33	NA	56.89	090
41250		A	Repair tongue laceration	1.91	2.75	1.18	0.18	4.84	3.27	010
41251		A	Repair tongue laceration	2.27	3.28	1.55	0.22	5.77	4.04	010
41252		A	Repair tongue laceration	2.97	3.90	2.26	0.29	7.16	5.52	010
41500		A	Fixation of tongue	3.70	NA	7.47	0.30	NA	11.47	090
41510		A	Tongue to lip surgery	3.41	NA	7.95	0.20	NA	11.56	090
41520		A	Reconstruction, tongue fold	2.73	4.63	3.63	0.27	7.63	6.63	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
41599	.....	C	Tongue and mouth surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
41800	.....	A	Drainage of gum lesion	1.17	2.60	1.28	0.12	3.89	2.57	010
41805	.....	A	Removal foreign body, gum	1.24	2.68	2.22	0.13	4.05	3.59	010
41806	.....	A	Removal foreign body,jawbone	2.69	3.59	3.04	0.37	6.65	6.10	010
41820	.....	R	Excision, gum, each quadrant	0.00	0.00	0.00	0.00	0.00	0.00	000
41821	.....	R	Excision of gum flap	0.00	0.00	0.00	0.00	0.00	0.00	000
41822	.....	R	Excision of gum lesion	2.31	3.90	1.88	0.31	6.52	4.50	010
41823	.....	R	Excision of gum lesion	3.30	5.58	4.02	0.47	9.35	7.79	090
41825	.....	A	Excision of gum lesion	1.31	3.07	2.25	0.15	4.53	3.71	010
41826	.....	A	Excision of gum lesion	2.31	2.44	2.11	0.30	5.05	4.72	010
41827	.....	A	Excision of gum lesion	3.41	5.53	3.67	0.35	9.29	7.43	090
41828	.....	R	Excision of gum lesion	3.09	3.81	2.97	0.44	7.34	6.50	010
41830	.....	R	Removal of gum tissue	3.34	4.97	3.63	0.44	8.75	7.41	010
41850	.....	R	Treatment of gum lesion	0.00	0.00	0.00	0.00	0.00	0.00	000
41870	.....	R	Gum graft	0.00	0.00	0.00	0.00	0.00	0.00	000
41872	.....	R	Repair gum	2.59	5.03	3.47	0.30	7.92	6.36	090
41874	.....	R	Repair tooth socket	3.09	4.85	3.18	0.45	8.39	6.72	090
41899	.....	C	Dental surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
42000	.....	A	Drainage mouth roof lesion	1.23	2.57	1.25	0.12	3.92	2.60	010
42100	.....	A	Biopsy roof of mouth	1.31	2.09	1.36	0.13	3.53	2.80	010
42104	.....	A	Excision lesion, mouth roof	1.64	2.55	1.55	0.16	4.35	3.35	010
42106	.....	A	Excision lesion, mouth roof	2.10	3.23	2.45	0.25	5.58	4.80	010
42107	.....	A	Excision lesion, mouth roof	4.43	5.73	3.96	0.44	10.60	8.83	090
42120	.....	A	Remove palate/lesion	6.16	NA	11.80	0.52	NA	18.48	090
42140	.....	A	Excision of uvula	1.62	3.73	2.10	0.13	5.48	3.85	090
42145	.....	A	Repair palate, pharynx/uvula	8.04	NA	7.51	0.65	NA	16.20	090
42160	.....	A	Treatment mouth roof lesion	1.80	4.26	2.30	0.17	6.23	4.27	010
42180	.....	A	Repair palate	2.50	3.08	2.11	0.21	5.79	4.82	010
42182	.....	A	Repair palate	3.82	3.88	3.04	0.40	8.10	7.26	010
42200	.....	A	Reconstruct cleft palate	11.98	NA	10.24	1.27	NA	23.49	090
42205	.....	A	Reconstruct cleft palate	13.27	NA	10.10	1.58	NA	24.95	090
42210	.....	A	Reconstruct cleft palate	14.48	NA	11.49	2.16	NA	28.13	090
42215	.....	A	Reconstruct cleft palate	8.81	NA	9.10	1.31	NA	19.22	090
42220	.....	A	Reconstruct cleft palate	7.01	NA	6.80	0.73	NA	14.54	090
42225	.....	A	Reconstruct cleft palate	9.53	NA	17.11	0.86	NA	27.50	090
42226	.....	A	Lengthening of palate	9.99	NA	14.74	1.01	NA	25.74	090
42227	.....	A	Lengthening of palate	9.51	NA	15.59	0.98	NA	26.08	090
42235	.....	A	Repair palate	7.86	NA	11.89	0.72	NA	20.47	090
42260	.....	A	Repair nose to lip fistula	9.79	10.22	7.08	1.26	21.27	18.13	090
42280	.....	A	Preparation, palate mold	1.54	1.97	1.14	0.19	3.70	2.87	010
42281	.....	A	Insertion, palate prosthesis	1.93	2.64	1.88	0.17	4.74	3.98	010
42299	.....	C	Palate/uvula surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
42300	.....	A	Drainage of salivary gland	1.93	2.83	1.82	0.16	4.92	3.91	010
42305	.....	A	Drainage of salivary gland	6.06	NA	4.73	0.51	NA	11.30	090
42310	.....	A	Drainage of salivary gland	1.56	2.27	1.54	0.13	3.96	3.23	010
42320	.....	A	Drainage of salivary gland	2.35	3.28	2.10	0.21	5.84	4.66	010
42330	.....	A	Removal of salivary stone	2.21	3.15	1.85	0.19	5.55	4.25	010
42335	.....	A	Removal of salivary stone	3.31	4.91	3.15	0.29	8.51	6.75	090
42340	.....	A	Removal of salivary stone	4.59	6.06	3.94	0.42	11.07	8.95	090
42400	.....	A	Biopsy of salivary gland	0.78	1.65	0.72	0.06	2.49	1.56	000
42405	.....	A	Biopsy of salivary gland	3.29	4.01	2.46	0.28	7.58	6.03	010
42408	.....	A	Excision of salivary cyst	4.53	5.93	3.62	0.45	10.91	8.60	090
42409	.....	A	Drainage of salivary cyst	2.81	4.53	2.77	0.27	7.61	5.85	090
42410	.....	A	Excise parotid gland/lesion	9.33	NA	6.24	0.91	NA	16.48	090
42415	.....	A	Excise parotid gland/lesion	16.86	NA	10.89	1.43	NA	29.18	090
42420	.....	A	Excise parotid gland/lesion	19.56	NA	12.41	1.65	NA	33.62	090
42425	.....	A	Excise parotid gland/lesion	13.00	NA	8.63	1.05	NA	22.68	090
42426	.....	A	Excise parotid gland/lesion	21.23	NA	13.05	1.80	NA	36.08	090
42440	.....	A	Excise submaxillary gland	6.96	NA	4.80	0.59	NA	12.35	090
42450	.....	A	Excise sublingual gland	4.61	5.92	4.26	0.42	10.95	9.29	090
42500	.....	A	Repair salivary duct	4.29	5.70	4.19	0.41	10.40	8.89	090
42505	.....	A	Repair salivary duct	6.17	7.14	5.38	0.55	13.86	12.10	090
42507	.....	A	Parotid duct diversion	6.10	NA	6.55	0.49	NA	13.14	090
42508	.....	A	Parotid duct diversion	9.09	NA	8.36	1.04	NA	18.49	090
42509	.....	A	Parotid duct diversion	11.52	NA	10.22	0.93	NA	22.67	090
42510	.....	A	Parotid duct diversion	8.14	NA	7.81	0.66	NA	16.61	090
42550	.....	A	Injection for salivary x-ray	1.25	3.22	0.41	0.07	4.54	1.73	000
42600	.....	A	Closure of salivary fistula	4.81	6.60	4.13	0.43	11.84	9.37	090
42650	.....	A	Dilation of salivary duct	0.77	1.10	0.71	0.07	1.94	1.55	000
42660	.....	A	Dilation of salivary duct	1.13	1.35	0.85	0.09	2.57	2.07	000
42665	.....	A	Ligation of salivary duct	2.53	4.18	2.60	0.23	6.94	5.36	090
42699	.....	C	Salivary surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
42700	.....	A	Drainage of tonsil abscess	1.62	2.66	1.70	0.13	4.41	3.45	010
42720	.....	A	Drainage of throat abscess	5.41	4.84	3.80	0.44	10.69	9.65	010
42725	.....	A	Drainage of throat abscess	10.70	NA	8.24	0.91	NA	19.85	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
42800	.....	A	Biopsy of throat	1.39	2.19	1.40	0.11	3.69	2.90	010
42802	.....	A	Biopsy of throat	1.54	4.77	2.07	0.12	6.43	3.73	010
42804	.....	A	Biopsy of upper nose/throat	1.24	3.75	1.74	0.10	5.09	3.08	010
42806	.....	A	Biopsy of upper nose/throat	1.58	4.08	1.94	0.13	5.79	3.65	010
42808	.....	A	Excise pharynx lesion	2.30	3.10	1.94	0.19	5.59	4.43	010
42809	.....	A	Remove pharynx foreign body	1.81	2.34	1.33	0.16	4.31	3.30	010
42810	.....	A	Excision of neck cyst	3.25	5.73	3.55	0.29	9.27	7.09	090
42815	.....	A	Excision of neck cyst	7.06	NA	6.43	0.61	NA	14.10	090
42820	.....	A	Remove tonsils and adenoids	3.90	NA	3.30	0.31	NA	7.51	090
42821	.....	A	Remove tonsils and adenoids	4.28	NA	3.51	0.35	NA	8.14	090
42825	.....	A	Removal of tonsils	3.41	NA	3.18	0.25	NA	6.84	090
42826	.....	A	Removal of tonsils	3.37	NA	3.04	0.27	NA	6.68	090
42830	.....	A	Removal of adenoids	2.57	NA	2.57	0.20	NA	5.34	090
42831	.....	A	Removal of adenoids	2.71	NA	2.85	0.22	NA	5.78	090
42835	.....	A	Removal of adenoids	2.30	NA	2.47	0.21	NA	4.98	090
42836	.....	A	Removal of adenoids	3.18	NA	2.97	0.26	NA	6.41	090
42842	.....	A	Extensive surgery of throat	8.75	NA	11.02	0.71	NA	20.48	090
42844	.....	A	Extensive surgery of throat	14.29	NA	16.28	1.16	NA	31.73	090
42845	.....	A	Extensive surgery of throat	24.25	NA	23.25	1.98	NA	49.48	090
42860	.....	A	Excision of tonsil tags	2.22	NA	2.41	0.18	NA	4.81	090
42870	.....	A	Excision of lingual tonsil	5.39	NA	8.59	0.44	NA	14.42	090
42890	.....	A	Partial removal of pharynx	12.92	NA	14.19	1.05	NA	28.16	090
42892	.....	A	Revision of pharyngeal walls	15.81	NA	17.22	1.28	NA	34.31	090
42894	.....	A	Revision of pharyngeal walls	22.85	NA	22.08	1.86	NA	46.79	090
42900	.....	A	Repair throat wound	5.24	NA	3.67	0.50	NA	9.41	010
42950	.....	A	Reconstruction of throat	8.09	NA	11.90	0.72	NA	20.71	090
42953	.....	A	Repair throat, esophagus	8.95	NA	17.38	0.88	NA	27.21	090
42955	.....	A	Surgical opening of throat	7.38	NA	10.70	0.80	NA	18.88	090
42960	.....	A	Control throat bleeding	2.33	NA	1.97	0.19	NA	4.49	010
42961	.....	A	Control throat bleeding	5.58	NA	4.97	0.45	NA	11.00	090
42962	.....	A	Control throat bleeding	7.13	NA	5.93	0.58	NA	13.64	090
42970	.....	A	Control nose/throat bleeding	5.42	NA	4.19	0.39	NA	10.00	090
42971	.....	A	Control nose/throat bleeding	6.20	NA	5.13	0.51	NA	11.84	090
42972	.....	A	Control nose/throat bleeding	7.19	NA	5.72	0.62	NA	13.53	090
42999	.....	C	Throat surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43020	.....	A	Incision of esophagus	8.08	NA	5.43	0.87	NA	14.38	090
43030	.....	A	Throat muscle surgery	7.68	NA	5.51	0.70	NA	13.89	090
43045	.....	A	Incision of esophagus	20.09	NA	10.73	2.58	NA	33.40	090
43100	.....	A	Excision of esophagus lesion	9.18	NA	6.24	0.93	NA	16.35	090
43101	.....	A	Excision of esophagus lesion	16.22	NA	7.90	2.31	NA	26.43	090
43107	.....	A	Removal of esophagus	39.94	NA	18.31	5.22	NA	63.47	090
43108	.....	A	Removal of esophagus	34.14	NA	14.25	4.07	NA	52.46	090
43112	.....	A	Removal of esophagus	43.43	NA	19.42	5.79	NA	68.64	090
43113	.....	A	Removal of esophagus	35.22	NA	15.15	4.42	NA	54.79	090
43116	.....	A	Partial removal of esophagus	31.17	NA	16.74	3.05	NA	50.96	090
43117	.....	A	Partial removal of esophagus	39.94	NA	17.32	5.17	NA	62.43	090
43118	.....	A	Partial removal of esophagus	33.15	NA	13.82	4.10	NA	51.07	090
43121	.....	A	Partial removal of esophagus	29.15	NA	13.71	3.90	NA	46.76	090
43122	.....	A	Partial removal of esophagus	39.94	NA	17.44	5.40	NA	62.78	090
43123	.....	A	Partial removal of esophagus	33.15	NA	14.14	4.15	NA	51.44	090
43124	.....	A	Removal of esophagus	27.28	NA	13.12	3.73	NA	44.13	090
43130	.....	A	Removal of esophagus pouch	11.73	NA	7.58	1.16	NA	20.47	090
43135	.....	A	Removal of esophagus pouch	16.08	NA	8.11	2.33	NA	26.52	090
43200	.....	A	Esophagus endoscopy	1.59	4.14	1.07	0.13	5.86	2.79	000
43201	.....	A	Esoph scope w/submucous inj	2.09	4.64	1.10	0.15	6.88	3.34	000
43202	.....	A	Esophagus endoscopy, biopsy	1.89	5.56	0.94	0.15	7.60	2.98	000
43204	.....	A	Esoph scope w/sclerosis inj	3.76	NA	1.52	0.30	NA	5.58	000
43205	.....	A	Esophagus endoscopy/ligation	3.78	NA	1.52	0.28	NA	5.58	000
43215	.....	A	Esophagus endoscopy	2.60	NA	1.20	0.22	NA	4.02	000
43216	.....	A	Esophagus endoscopy/lesion	2.40	NA	1.06	0.20	NA	3.66	000
43217	.....	A	Esophagus endoscopy	2.90	6.97	1.19	0.26	10.13	4.35	000
43219	.....	A	Esophagus endoscopy	2.80	NA	1.35	0.24	NA	4.39	000
43220	.....	A	Esoph endoscopy, dilation	2.10	NA	0.97	0.17	NA	3.24	000
43226	.....	A	Esoph endoscopy, dilation	2.34	NA	1.03	0.19	NA	3.56	000
43227	.....	A	Esoph endoscopy, repair	3.59	NA	1.45	0.28	NA	5.32	000
43228	.....	A	Esoph endoscopy, ablation	3.76	NA	1.55	0.34	NA	5.65	000
43231	.....	A	Esoph endoscopy w/us exam	3.19	NA	1.31	0.23	NA	4.73	000
43232	.....	A	Esoph endoscopy w/us fn bx	4.47	NA	1.82	0.34	NA	6.63	000
43234	.....	A	Upper GI endoscopy, exam	2.01	5.34	0.87	0.17	7.52	3.05	000
43235	.....	A	Uppr gi endoscopy, diagnosis	2.39	5.18	1.02	0.19	7.76	3.60	000
43236	.....	A	Uppr gi scope w/submuc inj	2.92	6.42	1.22	0.21	9.55	4.35	000
43237	.....	A	Endoscopic us exam, esoph	3.98	NA	1.59	0.43	NA	6.00	000
43238	.....	A	Uppr gi endoscopy w/us fn bx	5.02	NA	1.97	0.43	NA	7.42	000
43239	.....	A	Upper GI endoscopy, biopsy	2.87	5.73	1.19	0.22	8.82	4.28	000
43240	.....	A	Esoph endoscope w/drain cyst	6.85	NA	2.61	0.56	NA	10.02	000

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
43241	.....	A	Upper GI endoscopy with tube	2.59	NA	1.10	0.21	NA	3.90	000
43242	.....	A	Uppr gi endoscopy w/us fn bx	7.30	NA	2.74	0.53	NA	10.57	000
43243	.....	A	Upper gi endoscopy & inject	4.56	NA	1.80	0.33	NA	6.69	000
43244	.....	A	Upper GI endoscopy/ligation	5.04	NA	1.97	0.37	NA	7.38	000
43245	.....	A	Uppr gi scope dilate strictr	3.18	NA	1.30	0.26	NA	4.74	000
43246	.....	A	Place gastrostomy tube	4.32	NA	1.69	0.34	NA	6.35	000
43247	.....	A	Operative upper GI endoscopy	3.38	NA	1.37	0.27	NA	5.02	000
43248	.....	A	Uppr gi endoscopy/guide wire	3.15	NA	1.31	0.23	NA	4.69	000
43249	.....	A	Esoph endoscopy, dilation	2.90	NA	1.21	0.22	NA	4.33	000
43250	.....	A	Upper GI endoscopy/tumor	3.20	NA	1.31	0.26	NA	4.77	000
43251	.....	A	Operative upper GI endoscopy	3.69	NA	1.48	0.29	NA	5.46	000
43255	.....	A	Operative upper GI endoscopy	4.81	NA	1.89	0.35	NA	7.05	000
43256	.....	A	Uppr gi endoscopy w/stent	4.34	NA	1.71	0.32	NA	6.37	000
43257	.....	A	Uppr gi scope w/thrml txmnt	5.50	NA	2.21	0.36	NA	8.07	000
43258	.....	A	Operative upper GI endoscopy	4.54	NA	1.79	0.33	NA	6.66	000
43259	.....	A	Endoscopic ultrasound exam	5.19	NA	2.00	0.35	NA	7.54	000
43260	.....	A	Endo cholangiopancreatograph	5.95	NA	2.29	0.43	NA	8.67	000
43261	.....	A	Endo cholangiopancreatograph	6.26	NA	2.40	0.46	NA	9.12	000
43262	.....	A	Endo cholangiopancreatograph	7.38	NA	2.79	0.54	NA	10.71	000
43263	.....	A	Endo cholangiopancreatograph	7.28	NA	2.77	0.54	NA	10.59	000
43264	.....	A	Endo cholangiopancreatograph	8.89	NA	3.32	0.65	NA	12.86	000
43265	.....	A	Endo cholangiopancreatograph	10.00	NA	3.70	0.73	NA	14.43	000
43267	.....	A	Endo cholangiopancreatograph	7.38	NA	2.79	0.54	NA	10.71	000
43268	.....	A	Endo cholangiopancreatograph	7.38	NA	2.89	0.54	NA	10.81	000
43269	.....	A	Endo cholangiopancreatograph	8.20	NA	3.08	0.60	NA	11.88	000
43271	.....	A	Endo cholangiopancreatograph	7.38	NA	2.79	0.54	NA	10.71	000
43272	.....	A	Endo cholangiopancreatograph	7.38	NA	2.79	0.54	NA	10.71	000
43280	.....	A	Laparoscopy, fundoplasty	17.22	NA	7.29	2.27	NA	26.78	090
43289	.....	C	Laparoscope proc, esoph	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43300	.....	A	Repair of esophagus	9.13	NA	6.39	1.12	NA	16.64	090
43305	.....	A	Repair esophagus and fistula	17.36	NA	10.72	1.54	NA	29.62	090
43310	.....	A	Repair of esophagus	25.35	NA	11.09	3.60	NA	40.04	090
43312	.....	A	Repair esophagus and fistula	28.38	NA	11.92	4.00	NA	44.30	090
43313	.....	A	Esophagoplasty congenital	45.21	NA	18.86	5.45	NA	69.52	090
43314	.....	A	Tracheo-esophagoplasty cong	50.19	NA	19.24	6.63	NA	76.06	090
43320	.....	A	Fuse esophagus & stomach	19.90	NA	9.23	2.73	NA	31.86	090
43324	.....	A	Revise esophagus & stomach	20.54	NA	8.79	2.75	NA	32.08	090
43325	.....	A	Revise esophagus & stomach	20.03	NA	8.81	2.59	NA	31.43	090
43326	.....	A	Revise esophagus & stomach	19.71	NA	9.32	2.84	NA	31.87	090
43330	.....	A	Repair of esophagus	19.74	NA	8.55	2.62	NA	30.91	090
43331	.....	A	Repair of esophagus	20.10	NA	9.81	2.93	NA	32.84	090
43340	.....	A	Fuse esophagus & intestine	19.58	NA	8.99	2.45	NA	31.02	090
43341	.....	A	Fuse esophagus & intestine	20.82	NA	10.04	2.91	NA	33.77	090
43350	.....	A	Surgical opening, esophagus	15.76	NA	8.46	1.42	NA	25.64	090
43351	.....	A	Surgical opening, esophagus	18.32	NA	9.82	2.46	NA	30.60	090
43352	.....	A	Surgical opening, esophagus	15.24	NA	8.40	2.05	NA	25.69	090
43360	.....	A	Gastrointestinal repair	35.65	NA	15.11	4.96	NA	55.72	090
43361	.....	A	Gastrointestinal repair	40.44	NA	16.93	4.49	NA	61.86	090
43400	.....	A	Ligate esophagus veins	21.17	NA	9.46	1.95	NA	32.58	090
43401	.....	A	Esophagus surgery for veins	22.06	NA	9.51	3.04	NA	34.61	090
43405	.....	A	Ligate/staple esophagus	19.98	NA	9.61	2.83	NA	32.42	090
43410	.....	A	Repair esophagus wound	13.45	NA	7.65	1.71	NA	22.81	090
43415	.....	A	Repair esophagus wound	24.96	NA	11.77	3.52	NA	40.25	090
43420	.....	A	Repair esophagus opening	14.33	NA	7.42	1.43	NA	23.18	090
43425	.....	A	Repair esophagus opening	21.00	NA	10.00	3.02	NA	34.02	090
43450	.....	A	Dilate esophagus	1.38	2.64	0.69	0.11	4.13	2.18	000
43453	.....	A	Dilate esophagus	1.51	6.08	0.73	0.11	7.70	2.35	000
43456	.....	A	Dilate esophagus	2.57	13.78	1.10	0.20	16.55	3.87	000
43458	.....	A	Dilate esophagus	3.06	6.67	1.28	0.24	9.97	4.58	000
43460	.....	A	Pressure treatment esophagus	3.79	NA	1.49	0.31	NA	5.59	000
43496	.....	C	Free jejunum flap, microvasc	0.00	0.00	0.00	0.00	0.00	0.00	090
43499	.....	C	Esophagus surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43500	.....	A	Surgical opening of stomach	11.03	NA	4.98	1.45	NA	17.46	090
43501	.....	A	Surgical repair of stomach	20.01	NA	8.32	2.64	NA	30.97	090
43502	.....	A	Surgical repair of stomach	23.10	NA	9.48	3.09	NA	35.67	090
43510	.....	A	Surgical opening of stomach	13.06	NA	6.60	1.48	NA	21.14	090
43520	.....	A	Incision of pyloric muscle	9.98	NA	5.27	1.36	NA	16.61	090
43600	.....	A	Biopsy of stomach	1.91	NA	0.66	0.14	NA	2.71	000
43605	.....	A	Biopsy of stomach	11.96	NA	5.30	1.58	NA	18.84	090
43610	.....	A	Excision of stomach lesion	14.58	NA	6.16	1.93	NA	22.67	090
43611	.....	A	Excision of stomach lesion	17.81	NA	7.58	2.35	NA	27.74	090
43620	.....	A	Removal of stomach	29.99	NA	11.82	3.95	NA	45.76	090
43621	.....	A	Removal of stomach	30.68	NA	12.00	4.03	NA	46.71	090
43622	.....	A	Removal of stomach	32.48	NA	12.62	4.29	NA	49.39	090
43631	.....	A	Removal of stomach, partial	22.56	NA	9.18	2.98	NA	34.72	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
43632	.....	A	Removal of stomach, partial	22.56	NA	9.18	2.98	NA	34.72	090
43633	.....	A	Removal of stomach, partial	23.07	NA	9.35	3.05	NA	35.47	090
43634	.....	A	Removal of stomach, partial	25.08	NA	10.11	3.32	NA	38.51	090
43635	.....	A	Removal of stomach, partial	2.06	NA	0.70	0.27	NA	3.03	ZZZ
43640	.....	A	Vagotomy & pylorus repair	16.99	NA	7.27	2.25	NA	26.51	090
43641	.....	A	Vagotomy & pylorus repair	17.24	NA	7.38	2.24	NA	26.86	090
43644	.....	A	Lap gastric bypass/roux-en-y	27.83	NA	11.24	3.15	NA	42.22	090
43645	.....	A	Lap gastr bypass incl smll i	29.96	NA	12.04	3.53	NA	45.53	090
43651	.....	A	Laparoscopy, vagus nerve	10.13	NA	4.77	1.33	NA	16.23	090
43652	.....	A	Laparoscopy, vagus nerve	12.13	NA	5.77	1.55	NA	19.45	090
43653	.....	A	Laparoscopy, gastrostomy	7.72	NA	4.19	1.01	NA	12.92	090
43659	.....	C	Laparoscope proc, stom	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43750	.....	A	Place gastrostomy tube	4.48	NA	2.20	0.43	NA	7.11	010
43752	.....	A	Nasal/orogastric w/stent	0.81	0.28	0.26	0.02	1.11	1.09	000
43760	.....	A	Change gastrostomy tube	1.10	2.09	0.45	0.09	3.28	1.64	000
43761	.....	A	Reposition gastrostomy tube	2.01	1.17	0.66	0.13	3.31	2.80	000
43770	.....	A	Lap, place gastr adjust band	16.71	NA	7.73	2.18	NA	26.62	090
43771	.....	A	Lap, revise adjust gast band	19.50	NA	8.61	2.54	NA	30.65	090
43772	.....	A	Lap, remove adjust gast band	15.00	NA	6.44	1.92	NA	23.36	090
43773	.....	A	Lap, change adjust gast band	19.50	NA	8.61	2.55	NA	30.66	090
43774	.....	A	Lap remov adj gast band/port	15.00	NA	6.58	1.84	NA	23.42	090
43800	.....	A	Reconstruction of pylorus	13.67	NA	5.91	1.81	NA	21.39	090
43810	.....	A	Fusion of stomach and bowel	14.63	NA	6.19	1.93	NA	22.75	090
43820	.....	A	Fusion of stomach and bowel	15.35	NA	6.42	2.03	NA	23.80	090
43825	.....	A	Fusion of stomach and bowel	19.19	NA	8.03	2.53	NA	29.75	090
43830	.....	A	Place gastrostomy tube	9.52	NA	4.85	1.25	NA	15.62	090
43831	.....	A	Place gastrostomy tube	7.83	NA	4.52	1.03	NA	13.38	090
43832	.....	A	Place gastrostomy tube	15.58	NA	6.86	1.97	NA	24.41	090
43840	.....	A	Repair of stomach lesion	15.54	NA	6.78	2.05	NA	24.37	090
43842	.....	A	V-band gastroplasty	18.44	NA	7.81	2.44	NA	28.69	090
43843	.....	A	Gastroplasty w/o v-band	18.62	NA	7.78	2.45	NA	28.85	090
43845	.....	A	Gastroplasty duodenal switch	31.00	10.80	10.80	4.05	45.85	45.85	090
43846	.....	A	Gastric bypass for obesity	24.01	NA	10.05	3.18	NA	37.24	090
43847	.....	A	Gastric bypass incl small i	26.88	NA	10.92	3.55	NA	41.35	090
43848	.....	A	Revision gastroplasty	29.35	NA	11.84	3.87	NA	45.06	090
43850	.....	A	Revise stomach-bowel fusion	24.68	NA	9.84	3.27	NA	37.79	090
43855	.....	A	Revise stomach-bowel fusion	26.12	NA	10.35	3.46	NA	39.93	090
43860	.....	A	Revise stomach-bowel fusion	24.96	NA	9.99	3.30	NA	38.25	090
43865	.....	A	Revise stomach-bowel fusion	26.48	NA	10.53	3.50	NA	40.51	090
43870	.....	A	Repair stomach opening	9.68	NA	4.52	1.27	NA	15.47	090
43880	.....	A	Repair stomach-bowel fistula	24.61	NA	9.92	3.26	NA	37.79	090
43886	.....	A	Revise gastric port, open	4.00	NA	3.14	0.25	NA	7.39	090
43887	.....	A	Remove gastric port, open	3.95	NA	2.78	0.51	NA	7.24	090
43888	.....	A	Change gastric port, open	5.80	NA	3.77	0.70	NA	10.27	090
43999	.....	C	Stomach surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
44005	.....	A	Freeing of bowel adhesion	16.21	NA	6.73	2.14	NA	25.08	090
44010	.....	A	Incision of small bowel	12.50	NA	5.46	1.64	NA	19.60	090
44015	.....	A	Insert needle cath bowel	2.62	NA	0.88	0.35	NA	3.85	ZZZ
44020	.....	A	Explore small intestine	13.97	NA	5.95	1.85	NA	21.77	090
44021	.....	A	Decompress small bowel	14.06	NA	5.98	1.86	NA	21.90	090
44025	.....	A	Incision of large bowel	14.26	NA	6.04	1.89	NA	22.19	090
44050	.....	A	Reduce bowel obstruction	14.01	NA	5.97	1.85	NA	21.83	090
44055	.....	A	Correct malrotation of bowel	21.97	NA	8.75	2.90	NA	33.62	090
44100	.....	A	Biopsy of bowel	2.01	NA	0.71	0.17	NA	2.89	000
44110	.....	A	Excise intestine lesion(s)	11.79	NA	5.24	1.55	NA	18.58	090
44111	.....	A	Excision of bowel lesion(s)	14.27	NA	6.12	1.86	NA	22.25	090
44120	.....	A	Removal of small intestine	16.97	NA	7.09	2.24	NA	26.30	090
44121	.....	A	Removal of small intestine	4.44	NA	1.52	0.58	NA	6.54	ZZZ
44125	.....	A	Removal of small intestine	17.51	NA	7.27	2.26	NA	27.04	090
44126	.....	A	Enterectomy w/o taper, cong	35.45	NA	14.15	4.68	NA	54.28	090
44127	.....	A	Enterectomy w/taper, cong	40.94	NA	15.76	5.75	NA	62.45	090
44128	.....	A	Enterectomy cong, add-on	4.44	NA	1.53	0.61	NA	6.58	ZZZ
44130	.....	A	Bowel to bowel fusion	14.47	NA	6.23	1.87	NA	22.57	090
44132	.....	R	Enterectomy, cadaver donor	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44133	.....	R	Enterectomy, live donor	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44135	.....	R	Intestine transplnt, cadaver	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44136	.....	R	Intestine transplant, live	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44137	.....	C	Remove intestinal allograft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44139	.....	A	Mobilization of colon	2.23	NA	0.76	0.28	NA	3.27	ZZZ
44140	.....	A	Partial removal of colon	20.97	NA	8.67	2.70	NA	32.34	090
44141	.....	A	Partial removal of colon	19.48	NA	10.07	2.52	NA	32.07	090
44143	.....	A	Partial removal of colon	22.96	NA	10.71	3.04	NA	36.71	090
44144	.....	A	Partial removal of colon	21.50	NA	9.64	2.85	NA	33.99	090
44145	.....	A	Partial removal of colon	26.38	NA	10.83	3.28	NA	40.49	090
44146	.....	A	Partial removal of colon	27.50	NA	12.89	3.40	NA	43.79	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
44147	.....	A	Partial removal of colon	20.68	NA	8.71	2.55	NA	31.94	090
44150	.....	A	Removal of colon	23.91	NA	12.05	3.03	NA	38.99	090
44151	.....	A	Removal of colon/ileostomy	26.84	NA	13.43	3.48	NA	43.75	090
44152	.....	A	Removal of colon/ileostomy	27.79	NA	11.62	3.51	NA	42.92	090
44153	.....	A	Removal of colon/ileostomy	30.54	NA	14.41	3.54	NA	48.49	090
44155	.....	A	Removal of colon/ileostomy	27.82	NA	13.34	3.27	NA	44.43	090
44156	.....	A	Removal of colon/ileostomy	30.74	NA	15.07	3.94	NA	49.75	090
44160	.....	A	Removal of colon	18.59	NA	7.76	2.36	NA	28.71	090
44180	.....	A	Lap, enterolysis	14.42	NA	6.25	1.85	NA	22.52	090
44186	.....	A	Lap, jejunostomy	9.77	NA	4.80	1.27	NA	15.84	090
44187	.....	A	Lap, ileo/jejuno-stomy	15.93	NA	8.29	1.95	NA	26.17	090
44188	.....	A	Lap, colostomy	17.61	NA	8.87	2.23	NA	28.71	090
44202	.....	A	Lap, enterectomy	22.01	NA	8.95	2.84	NA	33.80	090
44203	.....	A	Lap resect s/intestine, addl	4.44	NA	1.50	0.57	NA	6.51	ZZZ
44204	.....	A	Laparo partial colectomy	25.04	NA	9.98	3.10	NA	38.12	090
44205	.....	A	Lap colectomy part w/ileum	22.20	NA	8.87	2.74	NA	33.81	090
44206	.....	A	Lap part colectomy w/stoma	26.96	NA	11.28	3.45	NA	41.69	090
44207	.....	A	L colectomy/coloproctostomy	29.96	NA	11.51	3.66	NA	45.13	090
44208	.....	A	L colectomy/coloproctostomy	31.95	NA	13.17	3.87	NA	48.99	090
44210	.....	A	Laparo total proctocolectomy	27.96	NA	11.90	3.41	NA	43.27	090
44211	.....	A	Laparo total proctocolectomy	34.95	NA	14.71	4.16	NA	53.82	090
44212	.....	A	Laparo total proctocolectomy	32.45	NA	13.72	3.77	NA	49.94	090
44213	.....	A	Lap, mobil splenic fl add-on	3.50	NA	1.22	0.44	NA	5.16	ZZZ
44227	.....	A	Lap, close enterostomy	26.50	NA	10.65	3.37	NA	40.52	090
44238	.....	C	Laparoscope proc, intestine	0.00	0.00	0.00	0.00	0.00	0.00	YYY
44300	.....	A	Open bowel to skin	12.09	NA	5.50	1.60	NA	19.19	090
44310	.....	A	Ileostomy/jejunostomy	15.93	NA	6.71	1.98	NA	24.62	090
44312	.....	A	Revision of ileostomy	8.01	NA	4.00	0.92	NA	12.93	090
44314	.....	A	Revision of ileostomy	15.03	NA	6.57	1.74	NA	23.34	090
44316	.....	A	Devise bowel pouch	21.06	NA	8.56	2.37	NA	31.99	090
44320	.....	A	Colostomy	17.61	NA	7.67	2.25	NA	27.53	090
44322	.....	A	Colostomy with biopsies	11.96	NA	8.59	1.54	NA	22.09	090
44340	.....	A	Revision of colostomy	7.71	NA	4.27	0.99	NA	12.97	090
44345	.....	A	Revision of colostomy	15.41	NA	6.90	1.96	NA	24.27	090
44346	.....	A	Revision of colostomy	16.96	NA	7.40	2.12	NA	26.48	090
44360	.....	A	Small bowel endoscopy	2.59	NA	1.10	0.19	NA	3.88	000
44361	.....	A	Small bowel endoscopy/biopsy	2.87	NA	1.20	0.21	NA	4.28	000
44363	.....	A	Small bowel endoscopy	3.49	NA	1.38	0.27	NA	5.14	000
44364	.....	A	Small bowel endoscopy	3.73	NA	1.49	0.27	NA	5.49	000
44365	.....	A	Small bowel endoscopy	3.31	NA	1.36	0.24	NA	4.91	000
44366	.....	A	Small bowel endoscopy	4.40	NA	1.74	0.32	NA	6.46	000
44369	.....	A	Small bowel endoscopy	4.51	NA	1.74	0.33	NA	6.58	000
44370	.....	A	Small bowel endoscopy/stent	4.79	NA	1.98	0.37	NA	7.14	000
44372	.....	A	Small bowel endoscopy	4.40	NA	1.74	0.35	NA	6.49	000
44373	.....	A	Small bowel endoscopy	3.49	NA	1.42	0.27	NA	5.18	000
44376	.....	A	Small bowel endoscopy	5.25	NA	2.03	0.42	NA	7.70	000
44377	.....	A	Small bowel endoscopy/biopsy	5.52	NA	2.14	0.40	NA	8.06	000
44378	.....	A	Small bowel endoscopy	7.12	NA	2.70	0.52	NA	10.34	000
44379	.....	A	S bowel endoscope w/stent	7.46	NA	2.92	0.62	NA	11.00	000
44380	.....	A	Small bowel endoscopy	1.05	NA	0.55	0.08	NA	1.68	000
44382	.....	A	Small bowel endoscopy	1.27	NA	0.63	0.12	NA	2.02	000
44383	.....	A	Ileoscopy w/stent	2.94	NA	1.27	0.21	NA	4.42	000
44385	.....	A	Endoscopy of bowel pouch	1.82	3.36	0.75	0.15	5.33	2.72	000
44386	.....	A	Endoscopy, bowel pouch/biop	2.12	6.66	0.88	0.20	8.98	3.20	000
44388	.....	A	Colonoscopy	2.82	5.09	1.15	0.26	8.17	4.23	000
44389	.....	A	Colonoscopy with biopsy	3.13	6.64	1.27	0.27	10.04	4.67	000
44390	.....	A	Colonoscopy for foreign body	3.82	7.13	1.49	0.32	11.27	5.63	000
44391	.....	A	Colonoscopy for bleeding	4.31	8.75	1.69	0.34	13.40	6.34	000
44392	.....	A	Colonoscopy & polypectomy	3.81	6.60	1.49	0.34	10.75	5.64	000
44393	.....	A	Colonoscopy, lesion removal	4.83	6.92	1.87	0.42	12.17	7.12	000
44394	.....	A	Colonoscopy w/snare	4.42	7.83	1.72	0.38	12.63	6.52	000
44397	.....	A	Colonoscopy w/stent	4.70	NA	1.80	0.39	NA	6.89	000
44500	.....	A	Intro, gastrointestinal tube	0.49	NA	0.16	0.03	NA	0.68	000
44602	.....	A	Suture, small intestine	16.01	NA	6.41	2.11	NA	24.53	090
44603	.....	A	Suture, small intestine	18.63	NA	7.29	2.41	NA	28.33	090
44604	.....	A	Suture, large intestine	16.01	NA	6.47	2.11	NA	24.59	090
44605	.....	A	Repair of bowel lesion	19.50	NA	8.41	2.51	NA	30.42	090
44615	.....	A	Intestinal stricturoplasty	15.91	NA	6.69	2.06	NA	24.66	090
44620	.....	A	Repair bowel opening	12.18	NA	5.34	1.51	NA	19.03	090
44625	.....	A	Repair bowel opening	15.03	NA	6.32	1.85	NA	23.20	090
44626	.....	A	Repair bowel opening	25.32	NA	9.84	3.26	NA	38.42	090
44640	.....	A	Repair bowel-skin fistula	21.62	NA	8.59	2.77	NA	32.98	090
44650	.....	A	Repair bowel fistula	22.54	NA	8.91	2.92	NA	34.37	090
44660	.....	A	Repair bowel-bladder fistula	21.33	NA	8.36	2.13	NA	31.82	090
44661	.....	A	Repair bowel-bladder fistula	24.77	NA	9.58	2.80	NA	37.15	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
44680	.....	A	Surgical revision, intestine	15.38	NA	6.46	1.99	NA	23.83	090
44700	.....	A	Suspend bowel w/prosthesis	16.09	NA	6.68	1.83	NA	24.60	090
44701	.....	A	Intraop colon lavage add-on	3.10	NA	1.06	0.37	NA	4.53	ZZZ
44715	.....	C	Prepare donor intestine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44720	.....	A	Prep donor intestine/venous	5.00	NA	1.71	0.37	NA	7.08	XXX
44721	.....	A	Prep donor intestine/artery	7.00	NA	2.40	0.97	NA	10.37	XXX
44799	.....	C	Unlisted procedure intestine	0.00	0.00	0.00	0.00	0.00	0.00	YYY
44800	.....	A	Excision of bowel pouch	11.21	NA	5.40	1.47	NA	18.08	090
44820	.....	A	Excision of mesentery lesion	12.07	NA	5.50	1.59	NA	19.16	090
44850	.....	A	Repair of mesentery	10.72	NA	5.01	1.39	NA	17.12	090
44899	.....	C	Bowel surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
44900	.....	A	Drain app abscess, open	10.12	NA	4.70	1.33	NA	16.15	090
44901	.....	A	Drain app abscess, percut	3.37	27.97	1.11	0.22	31.56	4.70	000
44950	.....	A	Appendectomy	9.99	NA	4.32	1.31	NA	15.62	090
44955	.....	A	Appendectomy add-on	1.53	NA	0.54	0.20	NA	2.27	ZZZ
44960	.....	A	Appendectomy	12.32	NA	5.35	1.63	NA	19.30	090
44970	.....	A	Laparoscopy, appendectomy	8.69	NA	4.09	1.14	NA	13.92	090
44979	.....	C	Laparoscope proc, app	0.00	0.00	0.00	0.00	0.00	0.00	YYY
45000	.....	A	Drainage of pelvic abscess	4.51	NA	2.97	0.52	NA	8.00	090
45005	.....	A	Drainage of rectal abscess	1.99	4.06	1.58	0.25	6.30	3.82	010
45020	.....	A	Drainage of rectal abscess	4.71	NA	3.28	0.55	NA	8.54	090
45100	.....	A	Biopsy of rectum	3.67	NA	2.37	0.44	NA	6.48	090
45108	.....	A	Removal of anorectal lesion	4.75	NA	2.78	0.59	NA	8.12	090
45110	.....	A	Removal of rectum	27.96	NA	12.43	3.35	NA	43.74	090
45111	.....	A	Partial removal of rectum	16.46	NA	7.18	2.06	NA	25.70	090
45112	.....	A	Removal of rectum	30.49	NA	11.79	3.42	NA	45.70	090
45113	.....	A	Partial proctectomy	30.53	NA	12.63	3.48	NA	46.64	090
45114	.....	A	Partial removal of rectum	27.28	NA	10.90	3.35	NA	41.53	090
45116	.....	A	Partial removal of rectum	24.54	NA	10.05	2.87	NA	37.46	090
45119	.....	A	Remove rectum w/reservoir	30.79	NA	12.49	3.35	NA	46.63	090
45120	.....	A	Removal of rectum	24.56	NA	10.15	2.89	NA	37.60	090
45121	.....	A	Removal of rectum and colon	27.00	NA	11.13	3.24	NA	41.37	090
45123	.....	A	Partial proctectomy	16.68	NA	6.87	1.85	NA	25.40	090
45126	.....	A	Pelvic exenteration	45.09	NA	19.26	4.32	NA	68.67	090
45130	.....	A	Excision of rectal prolapse	16.42	NA	6.78	1.79	NA	24.99	090
45135	.....	A	Excision of rectal prolapse	19.25	NA	8.43	2.35	NA	30.03	090
45136	.....	A	Excise ileoanal reservior	27.26	NA	12.55	2.81	NA	42.62	090
45150	.....	A	Excision of rectal stricture	5.66	NA	2.97	0.61	NA	9.24	090
45160	.....	A	Excision of rectal lesion	15.30	NA	6.66	1.67	NA	23.63	090
45170	.....	A	Excision of rectal lesion	11.47	NA	5.25	1.35	NA	18.07	090
45190	.....	A	Destruction, rectal tumor	9.73	NA	4.63	1.13	NA	15.49	090
45300	.....	A	Proctosigmoidoscopy dx	0.38	1.53	0.28	0.04	1.95	0.70	000
45303	.....	A	Proctosigmoidoscopy dilate	0.44	18.73	0.33	0.05	19.22	0.82	000
45305	.....	A	Proctosigmoidoscopy w/bx	1.01	2.64	0.50	0.11	3.76	1.62	000
45307	.....	A	Proctosigmoidoscopy fb	0.94	3.04	0.48	0.11	4.09	1.53	000
45308	.....	A	Proctosigmoidoscopy removal	0.83	2.00	0.44	0.09	2.92	1.36	000
45309	.....	A	Proctosigmoidoscopy removal	2.01	2.82	0.84	0.22	5.05	3.07	000
45315	.....	A	Proctosigmoidoscopy removal	1.40	2.87	0.63	0.15	4.42	2.18	000
45317	.....	A	Proctosigmoidoscopy bleed	1.50	2.44	0.66	0.15	4.09	2.31	000
45320	.....	A	Proctosigmoidoscopy ablate	1.58	2.92	0.71	0.16	4.66	2.45	000
45321	.....	A	Proctosigmoidoscopy volvul	1.17	NA	0.56	0.13	NA	1.86	000
45327	.....	A	Proctosigmoidoscopy w/stent	1.65	NA	0.69	0.16	NA	2.50	000
45330	.....	A	Diagnostic sigmoidoscopy	0.96	2.28	0.50	0.08	3.32	1.54	000
45331	.....	A	Sigmoidoscopy and biopsy	1.15	3.08	0.59	0.09	4.32	1.83	000
45332	.....	A	Sigmoidoscopy w/fb removal	1.79	5.01	0.80	0.16	6.96	2.75	000
45333	.....	A	Sigmoidoscopy & polypectomy	1.79	4.88	0.80	0.15	6.82	2.74	000
45334	.....	A	Sigmoidoscopy for bleeding	2.73	NA	1.14	0.20	NA	4.07	000
45335	.....	A	Sigmoidoscopy w/submuc inj	1.46	3.22	0.69	0.11	4.79	2.26	000
45337	.....	A	Sigmoidoscopy & decompress	2.36	NA	1.00	0.21	NA	3.57	000
45338	.....	A	Sigmoidoscopy w/tumr remove	2.34	5.23	1.00	0.19	7.76	3.53	000
45339	.....	A	Sigmoidoscopy w/ablate tumr	3.14	3.47	1.28	0.26	6.87	4.68	000
45340	.....	A	Sig w/balloon dilation	1.89	6.19	0.83	0.15	8.23	2.87	000
45341	.....	A	Sigmoidoscopy w/ultrasound	2.60	NA	1.07	0.19	NA	3.86	000
45342	.....	A	Sigmoidoscopy w/us guide bx	4.05	NA	1.54	0.30	NA	5.89	000
45345	.....	A	Sigmoidoscopy w/stent	2.92	NA	1.16	0.23	NA	4.31	000
45355	.....	A	Surgical colonoscopy	3.51	NA	1.38	0.36	NA	5.25	000
45378	53	A	Diagnostic colonoscopy	0.96	2.28	0.50	0.08	3.32	1.54	000
45378	.....	A	Diagnostic colonoscopy	3.69	6.16	1.47	0.30	10.15	5.46	000
45379	.....	A	Colonoscopy w/fb removal	4.68	7.68	1.82	0.39	12.75	6.89	000
45380	.....	A	Colonoscopy and biopsy	4.43	7.21	1.74	0.35	11.99	6.52	000
45381	.....	A	Colonoscopy, submucous inj	4.19	7.13	1.65	0.30	11.62	6.14	000
45382	.....	A	Colonoscopy/control bleeding	5.68	9.97	2.19	0.41	16.06	8.28	000
45383	.....	A	Lesion removal colonoscopy	5.86	7.94	2.23	0.48	14.28	8.57	000
45384	.....	A	Lesion remove colonoscopy	4.69	6.82	1.83	0.38	11.89	6.90	000
45385	.....	A	Lesion removal colonoscopy	5.30	7.82	2.04	0.42	13.54	7.76	000

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
45386	.....	A	Colonoscopy dilate stricture	4.57	12.44	1.79	0.39	17.40	6.75	000
45387	.....	A	Colonoscopy w/stent	5.90	NA	2.34	0.48	NA	8.72	000
45391	.....	A	Colonoscopy w/endoscope us	5.09	NA	1.98	0.42	NA	7.49	000
45392	.....	A	Colonoscopy w/endoscopic fnb	6.54	NA	2.49	0.42	NA	9.45	000
45395	.....	A	Lap, removal of rectum	30.50	NA	13.71	3.62	NA	47.83	090
45397	.....	A	Lap, remove rectum w/pouch	34.00	NA	14.30	3.66	NA	51.96	090
45400	.....	A	Laparoscopic proctopexy	18.06	NA	7.85	2.02	NA	27.93	090
45402	.....	A	Lap proctopexy w/sig resect	25.04	NA	10.01	2.81	NA	37.86	090
45499	.....	C	Laparoscope proc, rectum	0.00	0.00	0.00	0.00	0.00	0.00	YYY
45500	.....	A	Repair of rectum	7.28	NA	3.54	0.75	NA	11.57	090
45505	.....	A	Repair of rectum	7.57	NA	3.86	0.86	NA	12.29	090
45520	.....	A	Treatment of rectal prolapse	0.55	1.64	0.37	0.05	2.24	0.97	000
45540	.....	A	Correct rectal prolapse	16.25	NA	6.81	1.84	NA	24.90	090
45541	.....	A	Correct rectal prolapse	13.38	NA	5.96	1.55	NA	20.89	090
45550	.....	A	Repair rectum/remove sigmoid	22.97	NA	9.24	2.61	NA	34.82	090
45560	.....	A	Repair of rectocele	10.56	NA	5.06	1.13	NA	16.75	090
45562	.....	A	Exploration/repair of rectum	15.36	NA	7.00	1.83	NA	24.19	090
45563	.....	A	Exploration/repair of rectum	23.43	NA	10.54	3.10	NA	37.07	090
45800	.....	A	Repair rect/bladder fistula	17.74	NA	7.44	1.85	NA	27.03	090
45805	.....	A	Repair fistula w/colostomy	20.75	NA	9.53	2.02	NA	32.30	090
45820	.....	A	Repair rectourethral fistula	18.45	NA	7.64	1.58	NA	27.67	090
45825	.....	A	Repair fistula w/colostomy	21.22	NA	9.84	2.31	NA	33.37	090
45900	.....	A	Reduction of rectal prolapse	2.61	NA	1.50	0.30	NA	4.41	010
45905	.....	A	Dilation of anal sphincter	2.30	NA	1.43	0.27	NA	4.00	010
45910	.....	A	Dilation of rectal narrowing	2.80	NA	1.66	0.30	NA	4.76	010
45915	.....	A	Remove rectal obstruction	3.14	4.33	2.10	0.30	7.77	5.54	010
45990	.....	A	Surg dx exam, anorectal	1.80	NA	0.79	0.17	NA	2.76	000
45999	.....	C	Rectum surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
46020	.....	A	Placement of seton	2.90	2.34	1.86	0.31	5.55	5.07	010
46030	.....	A	Removal of rectal marker	1.23	1.35	0.71	0.14	2.72	2.08	010
46040	.....	A	Incision of rectal abscess	4.95	5.51	3.59	0.62	11.08	9.16	090
46045	.....	A	Incision of rectal abscess	4.31	NA	2.90	0.54	NA	7.75	090
46050	.....	A	Incision of anal abscess	1.19	2.55	0.84	0.14	3.88	2.17	010
46060	.....	A	Incision of rectal abscess	5.68	NA	3.25	0.67	NA	9.60	090
46070	.....	A	Incision of anal septum	2.71	NA	1.84	0.36	NA	4.91	090
46080	.....	A	Incision of anal sphincter	2.49	2.37	1.13	0.30	5.16	3.92	010
46083	.....	A	Incise external hemorrhoid	1.40	2.53	0.92	0.15	4.08	2.47	010
46200	.....	A	Removal of anal fissure	3.41	3.86	2.87	0.39	7.66	6.67	090
46210	.....	A	Removal of anal crypt	2.67	5.12	2.63	0.31	8.10	5.61	090
46211	.....	A	Removal of anal crypts	4.24	5.42	3.51	0.48	10.14	8.23	090
46220	.....	A	Removal of anal tag	1.56	2.30	0.95	0.17	4.03	2.68	010
46221	.....	A	Ligation of hemorrhoid(s)	2.04	2.65	1.75	0.23	4.92	4.02	010
46230	.....	A	Removal of anal tags	2.57	3.08	1.29	0.30	5.95	4.16	010
46250	.....	A	Hemorrhoidectomy	3.88	5.32	2.62	0.48	9.68	6.98	090
46255	.....	A	Hemorrhoidectomy	4.59	5.85	2.84	0.58	11.02	8.01	090
46257	.....	A	Remove hemorrhoids & fissure	5.39	NA	2.88	0.64	NA	8.91	090
46258	.....	A	Remove hemorrhoids & fistula	5.72	NA	3.28	0.68	NA	9.68	090
46260	.....	A	Hemorrhoidectomy	6.36	NA	3.19	0.76	NA	10.31	090
46261	.....	A	Remove hemorrhoids & fissure	7.07	NA	3.61	0.79	NA	11.47	090
46262	.....	A	Remove hemorrhoids & fistula	7.49	NA	3.74	0.83	NA	12.06	090
46270	.....	A	Removal of anal fistula	3.71	5.00	2.84	0.46	9.17	7.01	090
46275	.....	A	Removal of anal fistula	4.55	4.64	2.98	0.52	9.71	8.05	090
46280	.....	A	Removal of anal fistula	5.97	NA	3.26	0.66	NA	9.89	090
46285	.....	A	Removal of anal fistula	4.08	3.77	2.75	0.44	8.29	7.27	090
46288	.....	A	Repair anal fistula	7.12	NA	3.68	0.79	NA	11.59	090
46320	.....	A	Removal of hemorrhoid clot	1.61	2.13	0.85	0.18	3.92	2.64	010
46500	.....	A	Injection into hemorrhoid(s)	1.61	2.12	1.15	0.16	3.89	2.92	010
46505	.....	A	Chemodenervation anal musc	2.86	3.05	1.97	0.14	6.05	4.97	010
46600	.....	A	Diagnostic anoscopy	0.50	1.56	0.34	0.05	2.11	0.89	000
46604	.....	A	Anoscopy and dilation	1.31	9.15	0.62	0.12	10.58	2.05	000
46606	.....	A	Anoscopy and biopsy	0.81	3.79	0.43	0.09	4.69	1.33	000
46608	.....	A	Anoscopy, remove for body	1.51	4.41	0.65	0.16	6.08	2.32	000
46610	.....	A	Anoscopy, remove lesion	1.32	4.04	0.61	0.15	5.51	2.08	000
46611	.....	A	Anoscopy	1.81	3.34	0.78	0.19	5.34	2.78	000
46612	.....	A	Anoscopy, remove lesions	2.34	5.20	0.98	0.28	7.82	3.60	000
46614	.....	A	Anoscopy, control bleeding	2.01	2.33	0.84	0.20	4.54	3.05	000
46615	.....	A	Anoscopy	2.68	2.49	1.07	0.33	5.50	4.08	000
46700	.....	A	Repair of anal stricture	9.12	NA	4.21	0.94	NA	14.27	090
46705	.....	A	Repair of anal stricture	6.89	NA	3.69	0.91	NA	11.49	090
46706	.....	A	Repr of anal fistula w/glue	2.39	NA	1.25	0.28	NA	3.92	010
46710	.....	A	Repr per/vag pouch sngl proc	16.00	NA	7.77	1.38	NA	25.15	090
46712	.....	A	Repr per/vag pouch dbl proc	34.00	NA	15.08	3.66	NA	52.74	090
46715	.....	A	Rep perf anoper fistu	7.19	NA	3.58	0.92	NA	11.69	090
46716	.....	A	Rep perf anoper/vestib fistu	15.05	NA	7.99	1.58	NA	24.62	090
46730	.....	A	Construction of absent anus	26.71	NA	12.05	2.46	NA	41.22	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
46735	.....	A	Construction of absent anus	32.12	NA	13.58	3.20	NA	48.90	090
46740	.....	A	Construction of absent anus	29.96	NA	13.26	2.41	NA	45.63	090
46742	.....	A	Repair of imperforated anus	35.75	NA	17.43	3.19	NA	56.37	090
46744	.....	A	Repair of cloacal anomaly	52.55	NA	21.17	6.38	NA	80.10	090
46746	.....	A	Repair of cloacal anomaly	58.13	NA	25.21	7.68	NA	91.02	090
46748	.....	A	Repair of cloacal anomaly	64.11	NA	23.70	3.36	NA	91.17	090
46750	.....	A	Repair of anal sphincter	10.23	NA	5.06	1.10	NA	16.39	090
46751	.....	A	Repair of anal sphincter	8.76	NA	5.43	0.94	NA	15.13	090
46753	.....	A	Reconstruction of anus	8.28	NA	3.85	0.94	NA	13.07	090
46754	.....	A	Removal of suture from anus	2.20	3.60	1.67	0.19	5.99	4.06	010
46760	.....	A	Repair of anal sphincter	14.41	NA	7.10	1.59	NA	23.10	090
46761	.....	A	Repair of anal sphincter	13.82	NA	6.02	1.43	NA	21.27	090
46762	.....	A	Implant artificial sphincter	12.69	NA	5.53	1.24	NA	19.46	090
46900	.....	A	Destruction, anal lesion(s)	1.91	2.59	1.27	0.17	4.67	3.35	010
46910	.....	A	Destruction, anal lesion(s)	1.86	2.91	1.06	0.19	4.96	3.11	010
46916	.....	A	Cryosurgery, anal lesion(s)	1.86	3.16	1.39	0.11	5.13	3.36	010
46917	.....	A	Laser surgery, anal lesions	1.86	9.15	1.12	0.21	11.22	3.19	010
46922	.....	A	Excision of anal lesion(s)	1.86	3.28	1.07	0.22	5.36	3.15	010
46924	.....	A	Destruction, anal lesion(s)	2.76	8.71	1.35	0.26	11.73	4.37	010
46934	.....	A	Destruction of hemorrhoids	3.50	5.08	2.96	0.32	8.90	6.78	090
46935	.....	A	Destruction of hemorrhoids	2.43	3.47	1.21	0.23	6.13	3.87	010
46936	.....	A	Destruction of hemorrhoids	3.68	4.88	2.50	0.34	8.90	6.52	090
46937	.....	A	Cryotherapy of rectal lesion	2.69	2.78	1.22	0.14	5.61	4.05	010
46938	.....	A	Cryotherapy of rectal lesion	4.65	4.00	3.06	0.58	9.23	8.29	090
46940	.....	A	Treatment of anal fissure	2.32	2.00	1.09	0.23	4.55	3.64	010
46942	.....	A	Treatment of anal fissure	2.04	1.84	1.02	0.19	4.07	3.25	010
46945	.....	A	Ligation of hemorrhoids	1.84	3.27	2.48	0.19	5.30	4.51	090
46946	.....	A	Ligation of hemorrhoids	2.58	3.73	2.40	0.27	6.58	5.25	090
46947	.....	A	Hemorrhoidopexy by stapling	5.20	NA	2.72	0.75	NA	8.67	090
46999	.....	C	Anus surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
47000	.....	A	Needle biopsy of liver	1.90	3.08	0.63	0.12	5.10	2.65	000
47001	.....	A	Needle biopsy, liver add-on	1.90	NA	0.65	0.25	NA	2.80	ZZZ
47010	.....	A	Open drainage, liver lesion	15.99	NA	8.41	1.80	NA	26.20	090
47011	.....	A	Percut drain, liver lesion	3.69	NA	1.21	0.22	NA	5.12	000
47015	.....	A	Inject/aspirate liver cyst	15.09	NA	7.50	1.83	NA	24.42	090
47100	.....	A	Wedge biopsy of liver	11.65	NA	6.05	1.53	NA	19.23	090
47120	.....	A	Partial removal of liver	35.45	NA	15.18	4.65	NA	55.28	090
47122	.....	A	Extensive removal of liver	55.05	NA	21.50	7.19	NA	83.74	090
47125	.....	A	Partial removal of liver	49.12	NA	19.56	6.45	NA	75.13	090
47130	.....	A	Partial removal of liver	53.27	NA	21.02	6.94	NA	81.23	090
47133	.....	X	Removal of donor liver	0.00	0.00	0.00	0.00	0.00	0.00	XXX
47135	.....	R	Transplantation of liver	81.40	NA	31.59	9.93	NA	122.92	090
47136	.....	R	Transplantation of liver	68.50	NA	27.09	8.41	NA	104.00	090
47140	.....	A	Partial removal, donor liver	54.92	NA	22.33	5.17	NA	82.42	090
47141	.....	A	Partial removal, donor liver	67.40	NA	26.98	5.17	NA	99.55	090
47142	.....	A	Partial removal, donor liver	74.89	NA	29.55	5.17	NA	109.61	090
47143	.....	C	Prep donor liver, whole	0.00	0.00	0.00	0.00	0.00	0.00	XXX
47144	.....	C	Prep donor liver, 3-segment	0.00	0.00	0.00	0.00	0.00	0.00	090
47145	.....	C	Prep donor liver, lobe split	0.00	0.00	0.00	0.00	0.00	0.00	090
47146	.....	A	Prep donor liver/venous	6.00	NA	2.06	0.83	NA	8.89	XXX
47147	.....	A	Prep donor liver/arterial	7.00	NA	2.40	0.97	NA	10.37	XXX
47300	.....	A	Surgery for liver lesion	15.06	NA	7.24	1.98	NA	24.28	090
47350	.....	A	Repair liver wound	19.53	NA	8.89	2.58	NA	31.00	090
47360	.....	A	Repair liver wound	26.88	NA	11.60	3.37	NA	41.85	090
47361	.....	A	Repair liver wound	47.05	NA	18.56	5.85	NA	71.46	090
47362	.....	A	Repair liver wound	18.48	NA	8.74	2.50	NA	29.72	090
47370	.....	A	Laparo ablate liver tumor rf	19.66	NA	8.15	2.55	NA	30.36	090
47371	.....	A	Laparo ablate liver cryosurg	19.66	NA	8.16	2.60	NA	30.42	090
47379	.....	C	Laparoscope procedure, liver	0.00	0.00	0.00	0.00	0.00	0.00	YYY
47380	.....	A	Open ablate liver tumor rf	22.97	NA	9.38	2.86	NA	35.21	090
47381	.....	A	Open ablate liver tumor cryo	23.24	NA	9.61	2.84	NA	35.69	090
47382	.....	A	Percut ablate liver rf	15.17	NA	6.09	0.96	NA	22.22	010
47399	.....	C	Liver surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
47400	.....	A	Incision of liver duct	32.44	NA	13.47	3.07	NA	48.98	090
47420	.....	A	Incision of bile duct	19.85	NA	8.78	2.62	NA	31.25	090
47425	.....	A	Incision of bile duct	19.80	NA	8.83	2.61	NA	31.24	090
47460	.....	A	Incise bile duct sphincter	18.01	NA	8.38	2.20	NA	28.59	090
47480	.....	A	Incision of gallbladder	10.80	NA	5.92	1.42	NA	18.14	090
47490	.....	A	Incision of gallbladder	7.22	NA	5.58	0.43	NA	13.23	090
47500	.....	A	Injection for liver x-rays	1.96	NA	0.64	0.12	NA	2.72	000
47505	.....	A	Injection for liver x-rays	0.76	NA	0.25	0.04	NA	1.05	000
47510	.....	A	Insert catheter, bile duct	7.82	NA	5.02	0.46	NA	13.30	090
47511	.....	A	Insert bile duct drain	10.48	NA	5.09	0.62	NA	16.19	090
47525	.....	A	Change bile duct catheter	5.54	15.13	2.81	0.33	21.00	8.68	010
47530	.....	A	Revise/reinsert bile tube	5.84	33.88	3.72	0.37	40.09	9.93	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
47550	.....	A	Bile duct endoscopy add-on	3.02	NA	1.02	0.40	NA	4.44	ZZZ
47552	.....	A	Biliary endoscopy thru skin	6.03	NA	2.38	0.42	NA	8.83	000
47553	.....	A	Biliary endoscopy thru skin	6.34	NA	2.07	0.37	NA	8.78	000
47554	.....	A	Biliary endoscopy thru skin	9.05	NA	3.36	0.96	NA	13.37	000
47555	.....	A	Biliary endoscopy thru skin	7.55	NA	2.47	0.45	NA	10.47	000
47556	.....	A	Biliary endoscopy thru skin	8.55	NA	2.79	0.50	NA	11.84	000
47560	.....	A	Laparoscopy w/cholangio	4.88	NA	1.67	0.65	NA	7.20	000
47561	.....	A	Laparo w/cholangio/biopsy	5.17	NA	1.92	0.66	NA	7.75	000
47562	.....	A	Laparoscopic cholecystectomy	11.07	NA	4.99	1.46	NA	17.52	090
47563	.....	A	Laparo cholecystectomy/graph	11.92	NA	5.31	1.58	NA	18.81	090
47564	.....	A	Laparo cholecystectomy/explr	14.21	NA	5.96	1.88	NA	22.05	090
47570	.....	A	Laparo cholecystoenterostomy	12.56	NA	5.38	1.65	NA	19.59	090
47579	.....	C	Laparoscope proc, biliary	0.00	0.00	0.00	0.00	0.00	0.00	YYY
47600	.....	A	Removal of gallbladder	13.56	NA	6.14	1.79	NA	21.49	090
47605	.....	A	Removal of gallbladder	14.67	NA	6.51	1.94	NA	23.12	090
47610	.....	A	Removal of gallbladder	18.79	NA	7.94	2.48	NA	29.21	090
47612	.....	A	Removal of gallbladder	18.75	NA	7.89	2.47	NA	29.11	090
47620	.....	A	Removal of gallbladder	20.61	NA	8.53	2.73	NA	31.87	090
47630	.....	A	Remove bile duct stone	9.10	NA	4.89	0.65	NA	14.64	090
47700	.....	A	Exploration of bile ducts	15.60	NA	7.42	2.06	NA	25.08	090
47701	.....	A	Bile duct revision	27.77	NA	11.50	3.67	NA	42.94	090
47711	.....	A	Excision of bile duct tumor	23.00	NA	9.94	3.04	NA	35.98	090
47712	.....	A	Excision of bile duct tumor	30.19	NA	12.44	3.92	NA	46.55	090
47715	.....	A	Excision of bile duct cyst	18.77	NA	8.44	2.48	NA	29.69	090
47716	.....	A	Fusion of bile duct cyst	16.42	NA	7.83	2.14	NA	26.39	090
47720	.....	A	Fuse gallbladder & bowel	15.89	NA	7.48	2.10	NA	25.47	090
47721	.....	A	Fuse upper gi structures	19.09	NA	8.57	2.52	NA	30.18	090
47740	.....	A	Fuse gallbladder & bowel	18.45	NA	8.38	2.41	NA	29.24	090
47741	.....	A	Fuse gallbladder & bowel	21.31	NA	9.30	2.82	NA	33.43	090
47760	.....	A	Fuse bile ducts and bowel	25.81	NA	10.86	3.41	NA	40.08	090
47765	.....	A	Fuse liver ducts & bowel	24.84	NA	10.81	3.29	NA	38.94	090
47780	.....	A	Fuse bile ducts and bowel	26.46	NA	11.22	3.49	NA	41.17	090
47785	.....	A	Fuse bile ducts and bowel	31.13	NA	12.93	4.09	NA	48.15	090
47800	.....	A	Reconstruction of bile ducts	23.27	NA	10.07	3.07	NA	36.41	090
47801	.....	A	Placement, bile duct support	15.15	NA	8.16	1.16	NA	24.47	090
47802	.....	A	Fuse liver duct & intestine	21.52	NA	9.68	2.85	NA	34.05	090
47900	.....	A	Suture bile duct injury	19.87	NA	8.88	2.64	NA	31.39	090
47999	.....	C	Bile tract surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
48000	.....	A	Drainage of abdomen	28.03	NA	11.52	3.47	NA	43.02	090
48001	.....	A	Placement of drain, pancreas	35.40	NA	13.90	4.68	NA	53.98	090
48005	.....	A	Resect/debride pancreas	42.11	NA	16.59	5.54	NA	64.24	090
48020	.....	A	Removal of pancreatic stone	15.68	NA	7.31	2.12	NA	25.11	090
48100	.....	A	Biopsy of pancreas, open	12.21	NA	5.60	1.62	NA	19.43	090
48102	.....	A	Needle biopsy, pancreas	4.67	7.97	1.95	0.28	12.92	6.90	010
48120	.....	A	Removal of pancreas lesion	15.83	NA	6.86	2.09	NA	24.78	090
48140	.....	A	Partial removal of pancreas	22.91	NA	9.55	3.02	NA	35.48	090
48145	.....	A	Partial removal of pancreas	23.98	NA	9.84	3.17	NA	36.99	090
48146	.....	A	Pancreatectomy	26.36	NA	12.00	3.49	NA	41.85	090
48148	.....	A	Removal of pancreatic duct	17.31	NA	7.61	2.29	NA	27.21	090
48150	.....	A	Partial removal of pancreas	47.93	NA	19.54	6.30	NA	73.77	090
48152	.....	A	Pancreatectomy	43.68	NA	18.23	5.78	NA	67.69	090
48153	.....	A	Pancreatectomy	47.82	NA	19.58	6.29	NA	73.69	090
48154	.....	A	Pancreatectomy	44.03	NA	18.26	5.82	NA	68.11	090
48155	.....	A	Removal of pancreas	24.60	NA	11.68	3.26	NA	39.54	090
48160	.....	N	Pancreas removal/transplant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
48180	.....	A	Fuse pancreas and bowel	24.68	NA	10.17	3.27	NA	38.12	090
48400	.....	A	Injection, intraop add-on	1.95	NA	0.64	0.15	NA	2.74	ZZZ
48500	.....	A	Surgery of pancreatic cyst	15.26	NA	7.34	2.02	NA	24.62	090
48510	.....	A	Drain pancreatic pseudocyst	14.29	NA	7.45	1.82	NA	23.56	090
48511	.....	A	Drain pancreatic pseudocyst	3.99	20.95	1.31	0.24	25.18	5.54	000
48520	.....	A	Fuse pancreas cyst and bowel	15.57	NA	6.71	2.05	NA	24.33	090
48540	.....	A	Fuse pancreas cyst and bowel	19.69	NA	8.12	2.60	NA	30.41	090
48545	.....	A	Pancreatorrhaphy	18.15	NA	7.99	2.37	NA	28.51	090
48547	.....	A	Duodenal exclusion	25.79	NA	10.50	3.41	NA	39.70	090
48550	.....	X	Donor pancreatectomy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
48551	.....	C	Prep donor pancreas	0.00	0.00	0.00	0.00	0.00	0.00	XXX
48552	.....	A	Prep donor pancreas/venous	4.30	NA	1.46	0.31	NA	6.07	XXX
48554	.....	R	Transpl allograft pancreas	34.12	NA	18.30	4.18	NA	56.60	090
48556	.....	A	Removal, allograft pancreas	15.69	NA	8.08	2.07	NA	25.84	090
48999	.....	C	Pancreas surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
49000	.....	A	Exploration of abdomen	11.66	NA	5.39	1.52	NA	18.57	090
49002	.....	A	Reopening of abdomen	10.47	NA	5.02	1.37	NA	16.86	090
49010	.....	A	Exploration behind abdomen	12.26	NA	5.91	1.51	NA	19.68	090
49020	.....	A	Drain abdominal abscess	22.81	NA	10.21	2.84	NA	35.86	090
49021	.....	A	Drain abdominal abscess	3.37	21.11	1.11	0.20	24.68	4.68	000

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
49040	.....	A	Drain, open, abdom abscess	13.50	NA	6.43	1.69	NA	21.62	090
49041	.....	A	Drain, percut, abdom abscess	3.99	19.57	1.31	0.24	23.80	5.54	000
49060	.....	A	Drain, open, retrop abscess	15.84	NA	7.44	1.74	NA	25.02	090
49061	.....	A	Drain, percut, retroper absc	3.69	19.68	1.21	0.22	23.59	5.12	000
49062	.....	A	Drain to peritoneal cavity	11.34	NA	5.44	1.39	NA	18.17	090
49080	.....	A	Puncture, peritoneal cavity	1.35	3.99	0.46	0.08	5.42	1.89	000
49081	.....	A	Removal of abdominal fluid	1.26	2.59	0.43	0.09	3.94	1.78	000
49085	.....	A	Remove abdomen foreign body	12.12	NA	5.51	1.62	NA	19.25	090
49180	.....	A	Biopsy, abdominal mass	1.73	3.11	0.57	0.10	4.94	2.40	000
49200	.....	A	Removal of abdominal lesion	10.23	NA	5.03	1.24	NA	16.50	090
49201	.....	A	Remove abdom lesion, complex	14.82	NA	7.04	1.87	NA	23.73	090
49215	.....	A	Excise sacral spine tumor	33.45	NA	14.08	4.37	NA	51.90	090
49220	.....	A	Multiple surgery, abdomen	14.86	NA	6.64	1.88	NA	23.38	090
49250	.....	A	Excision of umbilicus	8.34	NA	4.27	1.08	NA	13.69	090
49255	.....	A	Removal of omentum	11.12	NA	5.62	1.43	NA	18.17	090
49320	.....	A	Diag laparo separate proc	5.09	NA	2.64	0.65	NA	8.38	010
49321	.....	A	Laparoscopy, biopsy	5.39	NA	2.65	0.70	NA	8.74	010
49322	.....	A	Laparoscopy, aspiration	5.69	NA	3.00	0.71	NA	9.40	010
49323	.....	A	Laparo drain lymphocele	9.47	NA	4.50	1.20	NA	15.17	090
49329	.....	C	Laparo proc, abdm/per/oment	0.00	0.00	0.00	0.00	0.00	0.00	YYY
49400	.....	A	Air injection into abdomen	1.88	3.08	0.62	0.15	5.11	2.65	000
49419	.....	A	Insrt abdom cath for chemotx	6.64	NA	3.57	0.81	NA	11.02	090
49420	.....	A	Insert abdom drain, temp	2.22	NA	1.09	0.21	NA	3.52	000
49421	.....	A	Insert abdom drain, perm	5.53	NA	3.16	0.74	NA	9.43	090
49422	.....	A	Remove perm cannula/catheter	6.24	NA	2.90	0.83	NA	9.97	010
49423	.....	A	Exchange drainage catheter	1.46	14.11	0.52	0.09	15.66	2.07	000
49424	.....	A	Assess cyst, contrast inject	0.76	3.72	0.29	0.04	4.52	1.09	000
49425	.....	A	Insert abdomen-venous drain	11.35	NA	5.61	1.54	NA	18.50	090
49426	.....	A	Revise abdomen-venous shunt	9.62	NA	4.77	1.28	NA	15.67	090
49427	.....	A	Injection, abdominal shunt	0.89	NA	0.30	0.07	NA	1.26	000
49428	.....	A	Ligation of shunt	6.05	NA	3.93	0.80	NA	10.78	010
49429	.....	A	Removal of shunt	7.39	NA	3.43	1.02	NA	11.84	010
49491	.....	A	Rpr hern preemie reduc	11.11	NA	5.06	1.40	NA	17.57	090
49492	.....	A	Rpr ing hern premie, blocked	14.01	NA	6.12	1.80	NA	21.93	090
49495	.....	A	Rpr ing hernia baby, reduc	5.88	NA	2.96	0.74	NA	9.58	090
49496	.....	A	Rpr ing hernia baby, blocked	8.78	NA	4.28	1.07	NA	14.13	090
49500	.....	A	Rpr ing hernia, init, reduce	5.47	NA	3.12	0.71	NA	9.30	090
49501	.....	A	Rpr ing hernia, init blocked	8.87	NA	4.21	1.12	NA	14.20	090
49505	.....	A	Prp i/hern init reduc >5 yr	7.59	NA	3.75	1.03	NA	12.37	090
49507	.....	A	Prp i/hern init block >5 yr	9.56	NA	4.46	1.27	NA	15.29	090
49520	.....	A	Rerepair ing hernia, reduce	9.62	NA	4.44	1.28	NA	15.34	090
49521	.....	A	Rerepair ing hernia, blocked	11.95	NA	5.25	1.59	NA	18.79	090
49525	.....	A	Repair ing hernia, sliding	8.56	NA	4.08	1.13	NA	13.77	090
49540	.....	A	Repair lumbar hernia	10.37	NA	4.75	1.37	NA	16.49	090
49550	.....	A	Rpr rem hernia, init, reduce	8.62	NA	4.13	1.14	NA	13.89	090
49553	.....	A	Rpr fem hernia, init blocked	9.43	NA	4.42	1.24	NA	15.09	090
49555	.....	A	Rerepair fem hernia, reduce	9.02	NA	4.27	1.20	NA	14.49	090
49557	.....	A	Rerepair fem hernia, blocked	11.13	NA	4.99	1.47	NA	17.59	090
49560	.....	A	Rpr ventral hern init, reduc	11.55	NA	5.15	1.52	NA	18.22	090
49561	.....	A	Rpr ventral hern init, block	14.23	NA	6.07	1.88	NA	22.18	090
49565	.....	A	Rerepair ventrl hern, reduce	11.55	NA	5.23	1.52	NA	18.30	090
49566	.....	A	Rerepair ventrl hern, block	14.38	NA	6.14	1.90	NA	22.42	090
49568	.....	A	Hernia repair w/mesh	4.88	NA	1.67	0.64	NA	7.19	ZZZ
49570	.....	A	Rpr epigastric hern, reduce	5.68	NA	3.17	0.75	NA	9.60	090
49572	.....	A	Rpr epigastric hern, blocked	6.72	NA	3.47	0.88	NA	11.07	090
49580	.....	A	Rpr umbil hern, reduc < 5 yr	4.10	NA	2.60	0.54	NA	7.24	090
49582	.....	A	Rpr umbil hern, block < 5 yr	6.64	NA	3.47	0.88	NA	10.99	090
49585	.....	A	Rpr umbil hern, reduc > 5 yr	6.22	NA	3.30	0.82	NA	10.34	090
49587	.....	A	Rpr umbil hern, block > 5 yr	7.55	NA	3.74	0.99	NA	12.28	090
49590	.....	A	Repair spigelian hernia	8.53	NA	4.09	1.13	NA	13.75	090
49600	.....	A	Repair umbilical lesion	10.94	NA	5.34	1.32	NA	17.60	090
49605	.....	A	Repair umbilical lesion	75.89	NA	28.58	9.36	NA	113.83	090
49606	.....	A	Repair umbilical lesion	18.57	NA	7.70	2.45	NA	28.72	090
49610	.....	A	Repair umbilical lesion	10.48	NA	5.21	1.07	NA	16.76	090
49611	.....	A	Repair umbilical lesion	8.91	NA	6.99	0.78	NA	16.68	090
49650	.....	A	Laparo hernia repair initial	6.26	NA	3.20	0.93	NA	10.39	090
49651	.....	A	Laparo hernia repair recur	8.23	NA	4.05	1.14	NA	13.42	090
49659	.....	C	Laparo proc, hernia repair	0.00	0.00	0.00	0.00	0.00	0.00	YYY
49900	.....	A	Repair of abdominal wall	12.26	NA	6.24	1.62	NA	20.12	090
49904	.....	A	Omental flap, extra-abdom	19.97	NA	15.25	2.69	NA	37.91	090
49905	.....	A	Omental flap, intra-abdom	6.54	NA	2.30	0.75	NA	9.59	ZZZ
49906	.....	C	Free omental flap, microvasc	0.00	0.00	0.00	0.00	0.00	0.00	090
49999	.....	C	Abdomen surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
50010	.....	A	Exploration of kidney	10.96	NA	5.23	0.93	NA	17.12	090
50020	.....	A	Renal abscess, open drain	14.64	NA	7.76	1.34	NA	23.74	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
50021	.....	A	Renal abscess, percut drain	3.37	21.71	1.10	0.20	25.28	4.67	000
50040	.....	A	Drainage of kidney	14.92	NA	6.82	1.03	NA	22.77	090
50045	.....	A	Exploration of kidney	15.44	NA	6.61	1.24	NA	23.29	090
50060	.....	A	Removal of kidney stone	19.27	NA	7.84	1.36	NA	28.47	090
50065	.....	A	Incision of kidney	20.76	NA	6.09	1.59	NA	28.44	090
50070	.....	A	Incision of kidney	20.29	NA	8.23	1.44	NA	29.96	090
50075	.....	A	Removal of kidney stone	25.30	NA	9.92	1.80	NA	37.02	090
50080	.....	A	Removal of kidney stone	14.69	NA	6.29	1.04	NA	22.02	090
50081	.....	A	Removal of kidney stone	21.77	NA	8.78	1.54	NA	32.09	090
50100	.....	A	Revise kidney blood vessels	16.07	NA	7.80	2.06	NA	25.93	090
50120	.....	A	Exploration of kidney	15.89	NA	6.78	1.21	NA	23.88	090
50125	.....	A	Explore and drain kidney	16.50	NA	6.98	1.43	NA	24.91	090
50130	.....	A	Removal of kidney stone	17.26	NA	7.18	1.22	NA	25.66	090
50135	.....	A	Exploration of kidney	19.15	NA	7.79	1.33	NA	28.27	090
50200	.....	A	Biopsy of kidney	2.63	NA	1.29	0.16	NA	4.08	000
50205	.....	A	Biopsy of kidney	11.29	NA	5.02	1.30	NA	17.61	090
50220	.....	A	Remove kidney, open	17.12	NA	7.25	1.35	NA	25.72	090
50225	.....	A	Removal kidney open, complex	20.20	NA	8.16	1.50	NA	29.86	090
50230	.....	A	Removal kidney open, radical	22.04	NA	8.59	1.55	NA	32.18	090
50234	.....	A	Removal of kidney & ureter	22.37	NA	8.85	1.59	NA	32.81	090
50236	.....	A	Removal of kidney & ureter	24.82	NA	10.27	1.76	NA	36.85	090
50240	.....	A	Partial removal of kidney	21.97	NA	9.03	1.55	NA	32.55	090
50250	.....	A	Cryoablate renal mass open	19.97	NA	9.18	1.39	NA	30.54	090
50280	.....	A	Removal of kidney lesion	15.65	NA	6.70	1.19	NA	23.54	090
50290	.....	A	Removal of kidney lesion	14.71	NA	6.47	1.41	NA	22.59	090
50300	.....	X	Remove cadaver donor kidney	0.00	0.00	0.00	0.00	0.00	0.00	XXX
50320	.....	A	Remove kidney, living donor	22.18	NA	10.68	2.35	NA	35.21	090
50323	.....	C	Prep cadaver renal allograft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
50325	.....	C	Prep donor renal graft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
50327	.....	A	Prep renal graft/venous	4.00	NA	1.35	0.29	NA	5.64	XXX
50328	.....	A	Prep renal graft/arterial	3.50	NA	1.18	0.26	NA	4.94	XXX
50329	.....	A	Prep renal graft/ureteral	3.34	NA	1.13	0.25	NA	4.72	XXX
50340	.....	A	Removal of kidney	12.13	NA	6.51	1.65	NA	20.29	090
50360	.....	A	Transplantation of kidney	31.48	NA	15.51	3.81	NA	50.80	090
50365	.....	A	Transplantation of kidney	36.75	NA	18.24	4.42	NA	59.41	090
50370	.....	A	Remove transplanted kidney	13.70	NA	7.16	1.67	NA	22.53	090
50380	.....	A	Reimplantation of kidney	20.73	NA	12.05	2.50	NA	35.28	090
50382	.....	A	Change ureter stent, percut	5.50	36.22	1.87	0.34	42.06	7.71	000
50384	.....	A	Remove ureter stent, percut	5.00	35.32	1.71	0.31	40.63	7.02	000
50387	.....	A	Change ext/int ureter stent	2.00	18.26	0.67	0.12	20.38	2.79	000
50389	.....	A	Remove renal tube w/fluoro	1.10	12.78	0.37	0.07	13.95	1.54	000
50390	.....	A	Drainage of kidney lesion	1.96	NA	0.64	0.12	NA	2.72	000
50391	.....	A	Instll rx agnt into rnal tub	1.96	1.58	0.63	0.14	3.68	2.73	000
50392	.....	A	Insert kidney drain	3.37	NA	1.52	0.20	NA	5.09	000
50393	.....	A	Insert ureteral tube	4.15	NA	1.79	0.25	NA	6.19	000
50394	.....	A	Injection for kidney x-ray	0.76	2.69	0.66	0.05	3.50	1.47	000
50395	.....	A	Create passage to kidney	3.37	NA	1.50	0.21	NA	5.08	000
50396	.....	A	Measure kidney pressure	2.09	NA	1.08	0.13	NA	3.30	000
50398	.....	A	Change kidney tube	1.46	16.36	0.52	0.09	17.91	2.07	000
50400	.....	A	Revision of kidney/ureter	19.47	NA	7.89	1.38	NA	28.74	090
50405	.....	A	Revision of kidney/ureter	23.89	NA	9.05	1.78	NA	34.72	090
50500	.....	A	Repair of kidney wound	19.54	NA	8.40	2.01	NA	29.95	090
50520	.....	A	Close kidney-skin fistula	17.20	NA	7.44	1.49	NA	26.13	090
50525	.....	A	Repair renal-abdomen fistula	22.24	NA	9.02	1.83	NA	33.09	090
50526	.....	A	Repair renal-abdomen fistula	23.98	NA	9.88	1.96	NA	35.82	090
50540	.....	A	Revision of horseshoe kidney	19.90	NA	8.34	1.36	NA	29.60	090
50541	.....	A	Laparo ablate renal cyst	15.98	NA	6.50	1.13	NA	23.61	090
50542	.....	A	Laparo ablate renal mass	19.97	NA	8.15	1.39	NA	29.51	090
50543	.....	A	Laparo partial nephrectomy	25.46	NA	10.22	1.80	NA	37.48	090
50544	.....	A	Laparoscopy, pyeloplasty	22.37	NA	8.54	1.58	NA	32.49	090
50545	.....	A	Laparo radical nephrectomy	23.96	NA	9.21	1.70	NA	34.87	090
50546	.....	A	Laparoscopic nephrectomy	20.45	NA	8.38	1.57	NA	30.40	090
50547	.....	A	Laparo removal donor kidney	25.46	NA	11.13	2.76	NA	39.35	090
50548	.....	A	Laparo remove w/ureter	24.36	NA	9.20	1.72	NA	35.28	090
50549	.....	C	Laparoscope proc, renal	0.00	0.00	0.00	0.00	0.00	0.00	YYY
50551	.....	A	Kidney endoscopy	5.59	4.15	1.98	0.40	10.14	7.97	000
50553	.....	A	Kidney endoscopy	5.98	4.37	2.18	0.39	10.74	8.55	000
50555	.....	A	Kidney endoscopy & biopsy	6.52	4.82	2.34	0.45	11.79	9.31	000
50557	.....	A	Kidney endoscopy & treatment	6.61	4.59	2.30	0.47	11.67	9.38	000
50561	.....	A	Kidney endoscopy & treatment	7.58	5.09	2.65	0.54	13.21	10.77	000
50562	.....	A	Renal scope w/tumor resect	10.90	NA	4.32	0.73	NA	15.95	090
50570	.....	A	Kidney endoscopy	9.53	NA	3.22	0.68	NA	13.43	000
50572	.....	A	Kidney endoscopy	10.33	NA	3.51	0.85	NA	14.69	000
50574	.....	A	Kidney endoscopy & biopsy	11.00	NA	3.75	0.77	NA	15.52	000
50575	.....	A	Kidney endoscopy	13.96	NA	4.64	0.99	NA	19.59	000

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
50576	.....	A	Kidney endoscopy & treatment	10.97	NA	3.67	0.78	NA	15.42	000
50580	.....	A	Kidney endoscopy & treatment	11.84	NA	3.97	0.83	NA	16.64	000
50590	.....	A	Fragmenting of kidney stone	9.08	12.43	4.12	0.65	22.16	13.85	090
50592	.....	A	Perc rf ablate renal tumor	6.75	149.45	2.99	0.43	156.63	10.17	010
50600	.....	A	Exploration of ureter	15.82	NA	6.68	1.13	NA	23.63	090
50605	.....	A	Insert ureteral support	15.44	NA	6.75	1.45	NA	23.64	090
50610	.....	A	Removal of ureter stone	15.90	NA	6.98	1.43	NA	24.31	090
50620	.....	A	Removal of ureter stone	15.14	NA	6.35	1.07	NA	22.56	090
50630	.....	A	Removal of ureter stone	14.92	NA	6.29	1.09	NA	22.30	090
50650	.....	A	Removal of ureter	17.38	NA	7.24	1.23	NA	25.85	090
50660	.....	A	Removal of ureter	19.52	NA	7.97	1.38	NA	28.87	090
50684	.....	A	Injection for ureter x-ray	0.76	4.98	0.47	0.05	5.79	1.28	000
50686	.....	A	Measure ureter pressure	1.51	3.45	0.82	0.11	5.07	2.44	000
50688	.....	A	Change of ureter tube/stent	1.17	NA	1.06	0.07	NA	2.30	010
50690	.....	A	Injection for ureter x-ray	1.16	1.83	0.72	0.07	3.06	1.95	000
50700	.....	A	Revision of ureter	15.19	NA	7.13	1.27	NA	23.59	090
50715	.....	A	Release of ureter	18.87	NA	8.76	2.13	NA	29.76	090
50722	.....	A	Release of ureter	16.33	NA	7.82	1.90	NA	26.05	090
50725	.....	A	Release/revise ureter	18.46	NA	8.06	1.52	NA	28.04	090
50727	.....	A	Revise ureter	8.17	NA	4.28	0.61	NA	13.06	090
50728	.....	A	Revise ureter	12.00	NA	5.57	1.00	NA	18.57	090
50740	.....	A	Fusion of ureter & kidney	18.39	NA	7.75	1.96	NA	28.10	090
50750	.....	A	Fusion of ureter & kidney	19.48	NA	8.00	1.38	NA	28.86	090
50760	.....	A	Fusion of ureters	18.39	NA	7.69	1.55	NA	27.63	090
50770	.....	A	Splicing of ureters	19.48	NA	7.99	1.45	NA	28.92	090
50780	.....	A	Reimplant ureter in bladder	18.33	NA	7.60	1.51	NA	27.44	090
50782	.....	A	Reimplant ureter in bladder	19.51	NA	8.79	1.61	NA	29.91	090
50783	.....	A	Reimplant ureter in bladder	20.52	NA	8.23	1.98	NA	30.73	090
50785	.....	A	Reimplant ureter in bladder	20.49	NA	8.31	1.45	NA	30.25	090
50800	.....	A	Implant ureter in bowel	14.50	NA	6.48	1.19	NA	22.17	090
50810	.....	A	Fusion of ureter & bowel	20.02	NA	9.11	2.31	NA	31.44	090
50815	.....	A	Urine shunt to intestine	19.90	NA	8.46	1.54	NA	29.90	090
50820	.....	A	Construct bowel bladder	21.86	NA	8.66	1.89	NA	32.41	090
50825	.....	A	Construct bowel bladder	28.14	NA	11.15	2.07	NA	41.36	090
50830	.....	A	Revise urine flow	31.23	NA	12.20	2.37	NA	45.80	090
50840	.....	A	Replace ureter by bowel	19.97	NA	8.44	1.47	NA	29.88	090
50845	.....	A	Appendico-vesicostomy	20.86	NA	8.92	1.57	NA	31.35	090
50860	.....	A	Transplant ureter to skin	15.34	NA	6.63	1.29	NA	23.26	090
50900	.....	A	Repair of ureter	13.60	NA	6.15	1.14	NA	20.89	090
50920	.....	A	Closure ureter/skin fistula	14.31	NA	6.58	1.01	NA	21.90	090
50930	.....	A	Closure ureter/bowel fistula	18.69	NA	7.98	1.28	NA	27.95	090
50940	.....	A	Release of ureter	14.49	NA	6.41	1.26	NA	22.16	090
50945	.....	A	Laparoscopy ureterolithotomy	16.97	NA	7.05	1.36	NA	25.38	090
50947	.....	A	Laparo new ureter/bladder	24.46	NA	9.71	2.16	NA	36.33	090
50948	.....	A	Laparo new ureter/bladder	22.47	NA	8.71	1.70	NA	32.88	090
50949	.....	C	Laparoscope proc, ureter	0.00	0.00	0.00	0.00	0.00	0.00	YYY
50951	.....	A	Endoscopy of ureter	5.83	4.30	2.06	0.41	10.54	8.30	000
50953	.....	A	Endoscopy of ureter	6.23	4.41	2.37	0.43	11.07	9.03	000
50955	.....	A	Ureter endoscopy & biopsy	6.74	6.43	2.69	0.48	13.65	9.91	000
50957	.....	A	Ureter endoscopy & treatment	6.78	4.57	2.38	0.48	11.83	9.64	000
50961	.....	A	Ureter endoscopy & treatment	6.04	4.37	2.19	0.41	10.82	8.64	000
50970	.....	A	Ureter endoscopy	7.13	NA	2.47	0.52	NA	10.12	000
50972	.....	A	Ureter endoscopy & catheter	6.88	NA	2.47	0.49	NA	9.84	000
50974	.....	A	Ureter endoscopy & biopsy	9.16	NA	3.11	0.64	NA	12.91	000
50976	.....	A	Ureter endoscopy & treatment	9.03	NA	3.07	0.66	NA	12.76	000
50980	.....	A	Ureter endoscopy & treatment	6.84	NA	2.38	0.48	NA	9.70	000
51000	.....	A	Drainage of bladder	0.78	1.95	0.24	0.05	2.78	1.07	000
51005	.....	A	Drainage of bladder	1.02	4.71	0.34	0.10	5.83	1.46	000
51010	.....	A	Drainage of bladder	3.52	5.62	1.88	0.28	9.42	5.68	010
51020	.....	A	Incise & treat bladder	6.70	NA	3.86	0.47	NA	11.03	090
51030	.....	A	Incise & treat bladder	6.76	NA	3.98	0.58	NA	11.32	090
51040	.....	A	Incise & drain bladder	4.39	NA	2.77	0.31	NA	7.47	090
51045	.....	A	Incise bladder/drain ureter	6.76	NA	3.93	0.52	NA	11.21	090
51050	.....	A	Removal of bladder stone	6.91	NA	3.65	0.49	NA	11.05	090
51060	.....	A	Removal of ureter stone	8.84	NA	4.51	0.62	NA	13.97	090
51065	.....	A	Remove ureter calculus	8.84	NA	4.36	0.63	NA	13.83	090
51080	.....	A	Drainage of bladder abscess	5.95	NA	3.55	0.43	NA	9.93	090
51500	.....	A	Removal of bladder cyst	10.12	NA	5.01	1.03	NA	16.16	090
51520	.....	A	Removal of bladder lesion	9.28	NA	4.68	0.69	NA	14.65	090
51525	.....	A	Removal of bladder lesion	13.95	NA	6.14	0.99	NA	21.08	090
51530	.....	A	Removal of bladder lesion	12.36	NA	5.76	1.05	NA	19.17	090
51535	.....	A	Repair of ureter lesion	12.55	NA	6.12	1.23	NA	19.90	090
51550	.....	A	Partial removal of bladder	15.64	NA	6.74	1.31	NA	23.69	090
51555	.....	A	Partial removal of bladder	21.20	NA	8.68	1.69	NA	31.57	090
51565	.....	A	Revise bladder & ureter(s)	21.59	NA	8.98	1.63	NA	32.20	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
51570	.....	A	Removal of bladder	24.20	NA	9.76	1.71	NA	35.67	090
51575	.....	A	Removal of bladder & nodes	30.40	NA	12.05	2.16	NA	44.61	090
51580	.....	A	Remove bladder/revise tract	31.03	NA	12.52	2.24	NA	45.79	090
51585	.....	A	Removal of bladder & nodes	35.18	NA	13.73	2.48	NA	51.39	090
51590	.....	A	Remove bladder/revise tract	32.61	NA	12.64	2.27	NA	47.52	090
51595	.....	A	Remove bladder/revise tract	37.08	NA	14.16	2.59	NA	53.83	090
51596	.....	A	Remove bladder/create pouch	39.46	NA	15.26	2.77	NA	57.49	090
51597	.....	A	Removal of pelvic structures	38.29	NA	14.86	2.81	NA	55.96	090
51600	.....	A	Injection for bladder x-ray	0.88	5.06	0.29	0.06	6.00	1.23	000
51605	.....	A	Preparation for bladder xray	0.64	6.07	0.35	0.04	6.75	1.03	000
51610	.....	A	Injection for bladder x-ray	1.05	2.29	0.60	0.07	3.41	1.72	000
51700	.....	A	Irrigation of bladder	0.88	1.60	0.28	0.06	2.54	1.22	000
51701	.....	A	Insert bladder catheter	0.50	1.58	0.19	0.04	2.12	0.73	000
51702	.....	A	Insert temp bladder cath	0.50	2.09	0.24	0.04	2.63	0.78	000
51703	.....	A	Insert bladder cath, complex	1.47	2.74	0.56	0.10	4.31	2.13	000
51705	.....	A	Change of bladder tube	1.02	2.28	0.61	0.07	3.37	1.70	010
51710	.....	A	Change of bladder tube	1.49	3.34	0.77	0.11	4.94	2.37	010
51715	.....	A	Endoscopic injection/implant	3.73	3.91	1.35	0.29	7.93	5.37	000
51720	.....	A	Treatment of bladder lesion	1.96	1.75	0.69	0.14	3.85	2.79	000
51725	26	A	Simple cystometrogram	1.51	0.49	0.49	0.12	2.12	2.12	000
51725	TC	A	Simple cystometrogram	0.00	5.11	NA	0.04	5.15	NA	000
51725	.....	A	Simple cystometrogram	1.51	5.60	NA	0.16	7.27	NA	000
51726	26	A	Complex cystometrogram	1.71	0.56	0.56	0.13	2.40	2.40	000
51726	TC	A	Complex cystometrogram	0.00	6.96	NA	0.05	7.01	NA	000
51726	.....	A	Complex cystometrogram	1.71	7.52	NA	0.18	9.41	NA	000
51736	26	A	Urine flow measurement	0.61	0.20	0.20	0.05	0.86	0.86	000
51736	TC	A	Urine flow measurement	0.00	0.38	NA	0.01	0.39	NA	000
51736	.....	A	Urine flow measurement	0.61	0.58	NA	0.06	1.25	NA	000
51741	26	A	Electro-uroflowmetry, first	1.14	0.37	0.37	0.09	1.60	1.60	000
51741	TC	A	Electro-uroflowmetry, first	0.00	0.42	NA	0.02	0.44	NA	000
51741	.....	A	Electro-uroflowmetry, first	1.14	0.79	NA	0.11	2.04	NA	000
51772	26	A	Urethra pressure profile	1.61	0.55	0.55	0.15	2.31	2.31	000
51772	TC	A	Urethra pressure profile	0.00	5.04	NA	0.05	5.09	NA	000
51772	.....	A	Urethra pressure profile	1.61	5.59	NA	0.20	7.40	NA	000
51784	26	A	Anal/urinary muscle study	1.53	0.50	0.50	0.12	2.15	2.15	000
51784	TC	A	Anal/urinary muscle study	0.00	3.49	NA	0.04	3.53	NA	000
51784	.....	A	Anal/urinary muscle study	1.53	3.99	NA	0.16	5.68	NA	000
51785	26	A	Anal/urinary muscle study	1.53	0.50	0.50	0.11	2.14	2.14	000
51785	TC	A	Anal/urinary muscle study	0.00	3.95	NA	0.04	3.99	NA	000
51785	.....	A	Anal/urinary muscle study	1.53	4.45	NA	0.15	6.13	NA	000
51792	26	A	Urinary reflex study	1.10	0.41	0.41	0.07	1.58	1.58	000
51792	TC	A	Urinary reflex study	0.00	5.60	NA	0.13	5.73	NA	000
51792	.....	A	Urinary reflex study	1.10	6.01	NA	0.20	7.31	NA	000
51795	26	A	Urine voiding pressure study	1.53	0.50	0.50	0.12	2.15	2.15	000
51795	TC	A	Urine voiding pressure study	0.00	6.81	NA	0.10	6.91	NA	000
51795	.....	A	Urine voiding pressure study	1.53	7.31	NA	0.22	9.06	NA	000
51797	26	A	Intraabdominal pressure test	1.60	0.53	0.53	0.12	2.25	2.25	000
51797	TC	A	Intraabdominal pressure test	0.00	5.27	NA	0.05	5.32	NA	000
51797	.....	A	Intraabdominal pressure test	1.60	5.80	NA	0.17	7.57	NA	000
51798	.....	A	Us urine capacity measure	0.00	0.34	NA	0.08	0.42	NA	XXX
51800	.....	A	Revision of bladder/urethra	17.39	NA	7.58	1.32	NA	26.29	090
51820	.....	A	Revision of urinary tract	17.86	NA	8.30	1.74	NA	27.90	090
51840	.....	A	Attach bladder/urethra	10.69	NA	5.58	1.06	NA	17.33	090
51841	.....	A	Attach bladder/urethra	13.01	NA	6.39	1.24	NA	20.64	090
51845	.....	A	Repair bladder neck	9.72	NA	4.75	0.79	NA	15.26	090
51860	.....	A	Repair of bladder wound	12.00	NA	5.77	1.16	NA	18.93	090
51865	.....	A	Repair of bladder wound	15.02	NA	6.69	1.23	NA	22.94	090
51880	.....	A	Repair of bladder opening	7.65	NA	3.96	0.72	NA	12.33	090
51900	.....	A	Repair bladder/vagina lesion	12.95	NA	6.08	1.21	NA	20.24	090
51920	.....	A	Close bladder-uterus fistula	11.79	NA	5.65	1.18	NA	18.62	090
51925	.....	A	Hysterectomy/bladder repair	15.56	NA	8.63	2.03	NA	26.22	090
51940	.....	A	Correction of bladder defect	28.39	NA	12.11	2.14	NA	42.64	090
51960	.....	A	Revision of bladder & bowel	22.98	NA	9.66	1.63	NA	34.27	090
51980	.....	A	Construct bladder opening	11.34	NA	5.39	0.86	NA	17.59	090
51990	.....	A	Laparo urethral suspension	12.48	NA	6.16	1.39	NA	20.03	090
51992	.....	A	Laparo sling operation	13.99	NA	6.22	1.41	NA	21.62	090
51999	.....	C	Laparoscope proc, bladder	0.00	0.00	0.00	0.00	0.00	0.00	YYY
52000	.....	A	Cystoscopy	2.01	3.31	0.76	0.14	5.46	2.91	000
52001	.....	A	Cystoscopy, removal of clots	5.44	5.08	1.87	0.39	10.91	7.70	000
52005	.....	A	Cystoscopy & ureter catheter	2.37	5.58	0.89	0.17	8.12	3.43	000
52007	.....	A	Cystoscopy and biopsy	3.02	16.49	1.15	0.22	19.73	4.39	000
52010	.....	A	Cystoscopy & duct catheter	3.02	10.78	1.15	0.21	14.01	4.38	000
52204	.....	A	Cystoscopy	2.37	14.55	0.90	0.17	17.09	3.44	000
52214	.....	A	Cystoscopy and treatment	3.70	38.21	1.33	0.26	42.17	5.29	000
52224	.....	A	Cystoscopy and treatment	3.14	36.56	1.15	0.22	39.92	4.51	000

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
52234	.....	A	Cystoscopy and treatment	4.62	NA	1.66	0.33	NA	6.61	000
52235	.....	A	Cystoscopy and treatment	5.44	NA	1.94	0.39	NA	7.77	000
52240	.....	A	Cystoscopy and treatment	9.71	NA	3.31	0.69	NA	13.71	000
52250	.....	A	Cystoscopy and radiotracer	4.49	NA	1.65	0.32	NA	6.46	000
52260	.....	A	Cystoscopy and treatment	3.91	NA	1.42	0.28	NA	5.61	000
52265	.....	A	Cystoscopy and treatment	2.94	13.38	1.11	0.22	16.54	4.27	000
52270	.....	A	Cystoscopy & revise urethra	3.36	11.06	1.24	0.24	14.66	4.84	000
52275	.....	A	Cystoscopy & revise urethra	4.69	15.60	1.66	0.33	20.62	6.68	000
52276	.....	A	Cystoscopy and treatment	4.99	NA	1.79	0.35	NA	7.13	000
52277	.....	A	Cystoscopy and treatment	6.16	NA	2.23	0.44	NA	8.83	000
52281	.....	A	Cystoscopy and treatment	2.80	7.11	1.08	0.20	10.11	4.08	000
52282	.....	A	Cystoscopy, implant stent	6.39	NA	2.24	0.45	NA	9.08	000
52283	.....	A	Cystoscopy and treatment	3.73	3.95	1.38	0.26	7.94	5.37	000
52285	.....	A	Cystoscopy and treatment	3.60	4.02	1.33	0.26	7.88	5.19	000
52290	.....	A	Cystoscopy and treatment	4.58	NA	1.65	0.32	NA	6.55	000
52300	.....	A	Cystoscopy and treatment	5.30	NA	1.91	0.38	NA	7.59	000
52301	.....	A	Cystoscopy and treatment	5.50	NA	1.99	0.46	NA	7.95	000
52305	.....	A	Cystoscopy and treatment	5.30	NA	1.86	0.38	NA	7.54	000
52310	.....	A	Cystoscopy and treatment	2.81	4.70	1.03	0.20	7.71	4.04	000
52315	.....	A	Cystoscopy and treatment	5.20	8.69	1.84	0.37	14.26	7.41	000
52317	.....	A	Remove bladder stone	6.71	29.02	2.29	0.48	36.21	9.48	000
52318	.....	A	Remove bladder stone	9.18	NA	3.10	0.65	NA	12.93	000
52320	.....	A	Cystoscopy and treatment	4.69	NA	1.63	0.33	NA	6.65	000
52325	.....	A	Cystoscopy, stone removal	6.15	NA	2.12	0.44	NA	8.71	000
52327	.....	A	Cystoscopy, inject material	5.18	31.90	1.82	0.37	37.45	7.37	000
52330	.....	A	Cystoscopy and treatment	5.03	38.93	1.76	0.36	44.32	7.15	000
52332	.....	A	Cystoscopy and treatment	2.83	5.76	1.05	0.21	8.80	4.09	000
52334	.....	A	Create passage to kidney	4.82	NA	1.74	0.35	NA	6.91	000
52341	.....	A	Cysto w/ureter stricture tx	5.99	NA	2.22	0.43	NA	8.64	000
52342	.....	A	Cysto w/up stricture tx	6.49	NA	2.35	0.46	NA	9.30	000
52343	.....	A	Cysto w/renal stricture tx	7.19	NA	2.59	0.51	NA	10.29	000
52344	.....	A	Cysto/uretero, stricture tx	7.69	NA	2.80	0.55	NA	11.04	000
52345	.....	A	Cysto/uretero w/up stricture	8.19	NA	2.96	0.58	NA	11.73	000
52346	.....	A	Cystouretero w/renal strict	9.22	NA	3.29	0.65	NA	13.16	000
52351	.....	A	Cystouretero & or pyeloscope	5.85	NA	2.15	0.41	NA	8.41	000
52352	.....	A	Cystouretero w/stone remove	6.87	NA	2.51	0.49	NA	9.87	000
52353	.....	A	Cystouretero w/lithotripsy	7.96	NA	2.86	0.57	NA	11.39	000
52354	.....	A	Cystouretero w/biopsy	7.33	NA	2.68	0.52	NA	10.53	000
52355	.....	A	Cystouretero w/excise tumor	8.81	NA	3.15	0.63	NA	12.59	000
52400	.....	A	Cystouretero w/congen repr	9.67	NA	3.74	0.68	NA	14.09	090
52402	.....	A	Cystourethro cut ejacul duct	5.27	NA	1.70	0.40	NA	7.37	000
52450	.....	A	Incision of prostate	7.63	NA	3.68	0.54	NA	11.85	090
52500	.....	A	Revision of bladder neck	8.46	NA	3.93	0.60	NA	12.99	090
52510	.....	A	Dilation prostatic urethra	6.71	NA	3.12	0.48	NA	10.31	090
52601	.....	A	Prostatectomy (TURP)	12.35	NA	5.11	0.87	NA	18.33	090
52606	.....	A	Control postop bleeding	8.12	NA	3.56	0.57	NA	12.25	090
52612	.....	A	Prostatectomy, first stage	7.97	NA	3.74	0.56	NA	12.27	090
52614	.....	A	Prostatectomy, second stage	6.83	NA	3.35	0.48	NA	10.66	090
52620	.....	A	Remove residual prostate	6.60	NA	2.99	0.47	NA	10.06	090
52630	.....	A	Remove prostate regrowth	7.25	NA	3.20	0.51	NA	10.96	090
52640	.....	A	Relieve bladder contracture	6.61	NA	2.97	0.47	NA	10.05	090
52647	.....	A	Laser surgery of prostate	10.34	74.15	4.54	0.73	85.22	15.61	090
52648	.....	A	Laser surgery of prostate	11.19	NA	4.80	0.79	NA	16.78	090
52700	.....	A	Drainage of prostate abscess	6.79	NA	3.19	0.48	NA	10.46	090
53000	.....	A	Incision of urethra	2.28	NA	1.54	0.16	NA	3.98	010
53010	.....	A	Incision of urethra	3.63	NA	2.92	0.24	NA	6.79	090
53020	.....	A	Incision of urethra	1.77	3.01	0.67	0.13	4.91	2.57	000
53025	.....	A	Incision of urethra	1.13	3.74	0.51	0.08	4.95	1.72	000
53040	.....	A	Drainage of urethra abscess	6.39	NA	3.44	0.45	NA	10.28	090
53060	.....	A	Drainage of urethra abscess	2.63	2.09	1.37	0.28	5.00	4.28	010
53080	.....	A	Drainage of urinary leakage	6.28	NA	5.97	0.52	NA	12.77	090
53085	.....	A	Drainage of urinary leakage	10.25	NA	7.42	0.92	NA	18.59	090
53200	.....	A	Biopsy of urethra	2.59	1.32	0.98	0.20	4.11	3.77	000
53210	.....	A	Removal of urethra	12.55	NA	5.85	0.89	NA	19.29	090
53215	.....	A	Removal of urethra	15.56	NA	6.64	1.10	NA	23.30	090
53220	.....	A	Treatment of urethra lesion	6.99	NA	3.72	0.49	NA	11.20	090
53230	.....	A	Removal of urethra lesion	9.57	NA	4.72	0.73	NA	15.02	090
53235	.....	A	Removal of urethra lesion	10.12	NA	4.91	0.72	NA	15.75	090
53240	.....	A	Surgery for urethra pouch	6.44	NA	3.53	0.52	NA	10.49	090
53250	.....	A	Removal of urethra gland	5.88	NA	3.30	0.49	NA	9.67	090
53260	.....	A	Treatment of urethra lesion	2.98	2.25	1.42	0.25	5.48	4.65	010
53265	.....	A	Treatment of urethra lesion	3.12	2.72	1.42	0.24	6.08	4.78	010
53270	.....	A	Removal of urethra gland	3.09	2.21	1.54	0.30	5.60	4.93	010
53275	.....	A	Repair of urethra defect	4.52	NA	2.26	0.32	NA	7.10	010
53400	.....	A	Revise urethra, stage 1	12.75	NA	6.04	0.98	NA	19.77	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
53405	.....	A	Revise urethra, stage 2	14.46	NA	6.33	1.10	NA	21.89	090
53410	.....	A	Reconstruction of urethra	16.42	NA	7.07	1.16	NA	24.65	090
53415	.....	A	Reconstruction of urethra	19.38	NA	7.35	1.37	NA	28.10	090
53420	.....	A	Reconstruct urethra, stage 1	14.06	NA	6.30	0.96	NA	21.32	090
53425	.....	A	Reconstruct urethra, stage 2	15.96	NA	6.90	1.13	NA	23.99	090
53430	.....	A	Reconstruction of urethra	16.32	NA	7.01	1.15	NA	24.48	090
53431	.....	A	Reconstruct urethra/bladder	19.86	NA	8.07	1.41	NA	29.34	090
53440	.....	A	Male sling procedure	13.60	NA	5.99	0.96	NA	20.55	090
53442	.....	A	Remove/revise male sling	11.55	NA	5.45	0.82	NA	17.82	090
53444	.....	A	Insert tandem cuff	13.38	NA	5.89	0.94	NA	20.21	090
53445	.....	A	Insert uro/ves nck sphincter	14.04	NA	7.10	0.99	NA	22.13	090
53446	.....	A	Remove uro sphincter	10.21	NA	5.23	0.72	NA	16.16	090
53447	.....	A	Remove/replace ur sphincter	13.47	NA	6.44	0.95	NA	20.86	090
53448	.....	A	Remov/replc ur sphinctr comp	21.12	NA	9.07	1.50	NA	31.69	090
53449	.....	A	Repair uro sphincter	9.69	NA	4.73	0.68	NA	15.10	090
53450	.....	A	Revision of urethra	6.13	NA	3.30	0.43	NA	9.86	090
53460	.....	A	Revision of urethra	7.11	NA	3.70	0.50	NA	11.31	090
53500	.....	A	Urethrlys, transvag w/ scope	12.19	NA	6.22	0.90	NA	19.31	090
53502	.....	A	Repair of urethra injury	7.62	NA	3.99	0.62	NA	12.23	090
53505	.....	A	Repair of urethra injury	7.62	NA	3.87	0.54	NA	12.03	090
53510	.....	A	Repair of urethra injury	10.09	NA	5.17	0.74	NA	16.00	090
53515	.....	A	Repair of urethra injury	13.29	NA	5.94	1.05	NA	20.28	090
53520	.....	A	Repair of urethra defect	8.67	NA	4.48	0.61	NA	13.76	090
53600	.....	A	Dilate urethra stricture	1.21	1.14	0.43	0.09	2.44	1.73	000
53601	.....	A	Dilate urethra stricture	0.98	1.27	0.37	0.07	2.32	1.42	000
53605	.....	A	Dilate urethra stricture	1.28	NA	0.41	0.09	NA	1.78	000
53620	.....	A	Dilate urethra stricture	1.62	2.00	0.59	0.11	3.73	2.32	000
53621	.....	A	Dilate urethra stricture	1.35	2.08	0.49	0.10	3.53	1.94	000
53660	.....	A	Dilation of urethra	0.71	1.31	0.31	0.05	2.07	1.07	000
53661	.....	A	Dilation of urethra	0.72	1.30	0.29	0.05	2.07	1.06	000
53665	.....	A	Dilation of urethra	0.76	NA	0.25	0.06	NA	1.07	000
53850	.....	A	Prostatic microwave thermotx	9.44	94.33	3.95	0.67	104.44	14.06	090
53852	.....	A	Prostatic rf thermotx	9.87	89.03	4.38	0.70	99.60	14.95	090
53853	.....	A	Prostatic water thermother	5.23	55.50	2.86	0.37	61.10	8.46	090
53899	.....	C	Urology surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
54000	.....	A	Slitting of prepuce	1.54	2.92	0.93	0.11	4.57	2.58	010
54001	.....	A	Slitting of prepuce	2.19	3.19	1.11	0.15	5.53	3.45	010
54015	.....	A	Drain penis lesion	5.31	NA	2.56	0.38	NA	8.25	010
54050	.....	A	Destruction, penis lesion(s)	1.24	1.66	1.03	0.08	2.98	2.35	010
54055	.....	A	Destruction, penis lesion(s)	1.22	1.57	0.80	0.08	2.87	2.10	010
54056	.....	A	Cryosurgery, penis lesion(s)	1.24	1.69	1.13	0.06	2.99	2.43	010
54057	.....	A	Laser surg, penis lesion(s)	1.24	2.22	0.83	0.09	3.55	2.16	010
54060	.....	A	Excision of penis lesion(s)	1.93	3.11	1.06	0.13	5.17	3.12	010
54065	.....	A	Destruction, penis lesion(s)	2.42	2.64	1.23	0.13	5.19	3.78	010
54100	.....	A	Biopsy of penis	1.90	2.81	0.82	0.10	4.81	2.82	000
54105	.....	A	Biopsy of penis	3.49	4.29	1.94	0.25	8.03	5.68	010
54110	.....	A	Treatment of penis lesion	10.11	NA	4.76	0.72	NA	15.59	090
54111	.....	A	Treat penis lesion, graft	13.55	NA	5.78	0.96	NA	20.29	090
54112	.....	A	Treat penis lesion, graft	15.84	NA	6.81	1.11	NA	23.76	090
54115	.....	A	Treatment of penis lesion	6.14	4.38	3.46	0.43	10.95	10.03	090
54120	.....	A	Partial removal of penis	9.96	NA	4.68	0.68	NA	15.32	090
54125	.....	A	Removal of penis	13.51	NA	5.84	0.95	NA	20.30	090
54130	.....	A	Remove penis & nodes	20.11	NA	8.19	1.52	NA	29.82	090
54135	.....	A	Remove penis & nodes	26.32	NA	10.19	1.87	NA	38.38	090
54150	.....	A	Circumcision	1.81	4.36	0.70	0.16	6.33	2.67	000
54152	.....	A	Circumcision	2.31	NA	1.20	0.19	NA	3.70	010
54160	.....	A	Circumcision	2.48	4.15	1.09	0.19	6.82	3.76	010
54161	.....	A	Circumcision	3.27	NA	1.56	0.23	NA	5.06	010
54162	.....	A	Lysis penil circumic lesion	3.00	4.66	1.44	0.21	7.87	4.65	010
54163	.....	A	Repair of circumcision	3.00	NA	2.01	0.21	NA	5.22	010
54164	.....	A	Frenulotomy of penis	2.50	NA	1.84	0.18	NA	4.52	010
54200	.....	A	Treatment of penis lesion	1.06	1.80	0.97	0.08	2.94	2.11	010
54205	.....	A	Treatment of penis lesion	7.92	NA	4.69	0.56	NA	13.17	090
54220	.....	A	Treatment of penis lesion	2.42	3.85	0.95	0.17	6.44	3.54	000
54230	.....	A	Prepare penis study	1.34	1.08	0.63	0.09	2.51	2.06	000
54231	.....	A	Dynamic cavernosometry	2.04	1.37	0.87	0.16	3.57	3.07	000
54235	.....	A	Penile injection	1.19	0.96	0.58	0.08	2.23	1.85	000
54240	26	A	Penis study	1.31	0.43	0.43	0.11	1.85	1.85	000
54240	TC	A	Penis study	0.00	0.60	NA	0.06	0.66	NA	000
54240	.....	A	Penis study	1.31	1.03	NA	0.17	2.51	NA	000
54250	26	A	Penis study	2.22	0.71	0.71	0.16	3.09	3.09	000
54250	TC	A	Penis study	0.00	0.20	NA	0.02	0.22	NA	000
54250	.....	A	Penis study	2.22	0.91	NA	0.18	3.31	NA	000
54300	.....	A	Revision of penis	10.39	NA	5.58	0.76	NA	16.73	090
54304	.....	A	Revision of penis	12.47	NA	6.34	0.88	NA	19.69	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
54308	.....	A	Reconstruction of urethra	11.81	NA	5.97	0.84	NA	18.62	090
54312	.....	A	Reconstruction of urethra	13.55	NA	7.00	1.24	NA	1.79	090
54316	.....	A	Reconstruction of urethra	16.79	NA	7.96	1.21	NA	25.96	090
54318	.....	A	Reconstruction of urethra	11.23	NA	5.80	1.39	NA	18.42	090
54322	.....	A	Reconstruction of urethra	12.99	NA	6.47	0.92	NA	20.38	090
54324	.....	A	Reconstruction of urethra	16.29	NA	7.97	1.14	NA	25.40	090
54326	.....	A	Reconstruction of urethra	15.70	NA	7.79	1.11	NA	24.60	090
54328	.....	A	Revise penis/urethra	15.63	NA	7.26	0.98	NA	23.87	090
54332	.....	A	Revise penis/urethra	17.05	NA	7.74	1.21	NA	26.00	090
54336	.....	A	Revise penis/urethra	20.01	NA	10.31	2.20	NA	32.52	090
54340	.....	A	Secondary urethral surgery	8.90	NA	5.04	0.63	NA	14.57	090
54344	.....	A	Secondary urethral surgery	15.92	NA	7.76	1.54	NA	25.22	090
54348	.....	A	Secondary urethral surgery	17.12	NA	8.36	1.23	NA	26.71	090
54352	.....	A	Reconstruct urethra/penis	24.70	NA	11.20	2.24	NA	38.14	090
54360	.....	A	Penis plastic surgery	11.91	NA	6.04	0.84	NA	18.79	090
54380	.....	A	Repair penis	13.16	NA	6.62	0.93	NA	20.71	090
54385	.....	A	Repair penis	15.37	NA	8.27	0.86	NA	24.50	090
54390	.....	A	Repair penis and bladder	21.58	NA	9.43	1.54	NA	32.55	090
54400	.....	A	Insert semi-rigid prosthesis	8.98	NA	4.35	0.64	NA	13.97	090
54401	.....	A	Insert self-contd prosthesis	10.26	NA	5.74	0.73	NA	16.73	090
54405	.....	A	Insert multi-comp penis pros	13.41	NA	5.93	0.95	NA	20.29	090
54406	.....	A	Remove muti-comp penis pros	12.08	NA	5.43	0.86	NA	18.37	090
54408	.....	A	Repair multi-comp penis pros	12.73	NA	5.74	0.90	NA	19.37	090
54410	.....	A	Remove/replace penis prosth	15.48	NA	6.63	1.10	NA	23.21	090
54411	.....	A	Remov/replc penis pros, comp	15.98	NA	7.05	1.13	NA	24.16	090
54415	.....	A	Remove self-contd penis pros	8.19	NA	4.20	0.58	NA	12.97	090
54416	.....	A	Remv/repl penis contain pros	10.85	NA	5.38	0.77	NA	17.00	090
54417	.....	A	Remv/replc penis pros, compl	14.17	NA	6.18	1.00	NA	21.35	090
54420	.....	A	Revision of penis	11.40	NA	5.58	0.81	NA	17.79	090
54430	.....	A	Revision of penis	10.13	NA	5.11	0.72	NA	15.96	090
54435	.....	A	Revision of penis	6.11	NA	3.62	0.43	NA	10.16	090
54440	.....	C	Repair of penis	0.00	0.00	0.00	0.00	0.00	0.00	090
54450	.....	A	Preputial stretching	1.12	0.95	0.44	0.08	2.15	1.64	000
54500	.....	A	Biopsy of testis	1.31	0.61	0.56	0.10	2.02	1.97	000
54505	.....	A	Biopsy of testis	3.45	NA	1.92	0.27	NA	5.64	010
54512	.....	A	Excise lesion testis	8.57	NA	4.13	0.67	NA	13.37	090
54520	.....	A	Removal of testis	5.22	NA	2.79	0.50	NA	8.51	090
54522	.....	A	Orchiectomy, partial	9.49	NA	4.87	0.89	NA	15.25	090
54530	.....	A	Removal of testis	8.57	NA	4.24	0.66	NA	13.47	090
54535	.....	A	Extensive testis surgery	12.14	NA	5.55	0.95	NA	18.64	090
54550	.....	A	Exploration for testis	7.77	NA	3.81	0.59	NA	12.17	090
54560	.....	A	Exploration for testis	11.11	NA	5.16	0.90	NA	17.17	090
54600	.....	A	Reduce testis torsion	7.00	NA	3.55	0.51	NA	11.06	090
54620	.....	A	Suspension of testis	4.89	NA	2.44	0.37	NA	7.70	010
54640	.....	A	Suspension of testis	6.89	NA	3.74	0.62	NA	11.25	090
54650	.....	A	Orchiopexy (Fowler-Stephens)	11.43	NA	5.41	1.16	NA	18.00	090
54660	.....	A	Revision of testis	5.10	NA	3.00	0.44	NA	8.54	090
54670	.....	A	Repair testis injury	6.40	NA	3.54	0.47	NA	10.41	090
54680	.....	A	Relocation of testis(es)	12.63	NA	6.16	1.16	NA	19.95	090
54690	.....	A	Laparoscopy, orchiectomy	10.94	NA	4.94	1.02	NA	16.90	090
54692	.....	A	Laparoscopy, orchiopexy	12.86	NA	5.44	1.30	NA	19.60	090
54699	.....	C	Laparoscope proc, testis	0.00	0.00	0.00	0.00	0.00	0.00	YYY
54700	.....	A	Drainage of scrotum	3.42	NA	1.94	0.28	NA	5.64	010
54800	.....	A	Biopsy of epididymis	2.33	0.94	0.90	0.23	3.50	3.46	000
54820	.....	A	Exploration of epididymis	5.13	NA	2.94	0.40	NA	8.47	090
54830	.....	A	Remove epididymis lesion	5.37	NA	3.02	0.41	NA	8.80	090
54840	.....	A	Remove epididymis lesion	5.19	NA	2.78	0.37	NA	8.34	090
54860	.....	A	Removal of epididymis	6.31	NA	3.31	0.45	NA	10.07	090
54861	.....	A	Removal of epididymis	8.89	NA	4.31	0.63	NA	13.83	090
54900	.....	A	Fusion of spermatic ducts	13.18	NA	5.80	0.93	NA	19.91	090
54901	.....	A	Fusion of spermatic ducts	17.91	NA	7.53	1.82	NA	27.26	090
55000	.....	A	Drainage of hydrocele	1.43	2.07	0.65	0.11	3.61	2.19	000
55040	.....	A	Removal of hydrocele	5.35	NA	2.90	0.43	NA	8.68	090
55041	.....	A	Removal of hydroceles	7.73	NA	3.97	0.60	NA	12.30	090
55060	.....	A	Repair of hydrocele	5.51	NA	3.08	0.46	NA	9.05	090
55100	.....	A	Drainage of scrotum abscess	2.13	3.68	1.56	0.17	5.98	3.86	010
55110	.....	A	Explore scrotum	5.69	NA	3.13	0.43	NA	9.25	090
55120	.....	A	Removal of scrotum lesion	5.08	NA	2.95	0.39	NA	8.42	090
55150	.....	A	Removal of scrotum	7.21	NA	3.84	0.56	NA	11.61	090
55175	.....	A	Revision of scrotum	5.23	NA	3.01	0.37	NA	8.61	090
55180	.....	A	Revision of scrotum	10.70	NA	5.37	0.90	NA	16.97	090
55200	.....	A	Incision of sperm duct	4.23	12.35	2.38	0.33	16.91	6.94	090
55250	.....	A	Removal of sperm duct(s)	3.29	11.50	2.22	0.25	15.04	5.76	090
55300	.....	A	Prepare, sperm duct x-ray	3.50	NA	1.31	0.25	NA	5.06	000
55400	.....	A	Repair of sperm duct	8.48	NA	4.06	0.64	NA	13.18	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
55450	.....	A	Ligation of sperm duct	4.11	7.01	1.87	0.29	11.41	6.27	010
55500	.....	A	Removal of hydrocele	5.58	NA	3.09	0.55	NA	9.22	090
55520	.....	A	Removal of sperm cord lesion	6.02	NA	3.25	0.75	NA	10.02	090
55530	.....	A	Revise spermatic cord veins	5.65	NA	3.01	0.45	NA	9.11	090
55535	.....	A	Revise spermatic cord veins	6.55	NA	3.40	0.47	NA	10.42	090
55540	.....	A	Revise hernia & sperm veins	7.66	NA	3.80	0.94	NA	12.40	090
55550	.....	A	Laparo ligate spermatic vein	6.56	NA	3.30	0.57	NA	10.43	090
55559	.....	C	Laparo proc, spermatic cord	0.00	0.00	0.00	0.00	0.00	0.00	YYY
55600	.....	A	Incise sperm duct pouch	6.37	NA	3.33	0.62	NA	10.32	090
55605	.....	A	Incise sperm duct pouch	7.95	NA	4.29	0.64	NA	12.88	090
55650	.....	A	Remove sperm duct pouch	11.78	NA	5.28	0.92	NA	17.98	090
55680	.....	A	Remove sperm pouch lesion	5.18	NA	2.97	0.47	NA	8.62	090
55700	.....	A	Biopsy of prostate	1.57	4.20	0.64	0.11	5.88	2.32	000
55705	.....	A	Biopsy of prostate	4.56	NA	2.30	0.32	NA	7.18	010
55720	.....	A	Drainage of prostate abscess	7.63	NA	3.82	0.95	NA	12.40	090
55725	.....	A	Drainage of prostate abscess	8.67	NA	4.49	0.70	NA	13.86	090
55801	.....	A	Removal of prostate	17.77	NA	7.62	1.34	NA	26.73	090
55810	.....	A	Extensive prostate surgery	22.55	NA	8.95	1.60	NA	33.10	090
55812	.....	A	Extensive prostate surgery	27.47	NA	10.99	2.04	NA	40.50	090
55815	.....	A	Extensive prostate surgery	30.41	NA	11.90	2.16	NA	44.47	090
55821	.....	A	Removal of prostate	14.23	NA	6.21	1.01	NA	21.45	090
55831	.....	A	Removal of prostate	15.60	NA	6.66	1.10	NA	23.36	090
55840	.....	A	Extensive prostate surgery	22.66	NA	9.29	1.61	NA	33.56	090
55842	.....	A	Extensive prostate surgery	24.34	NA	9.85	1.72	NA	35.91	090
55845	.....	A	Extensive prostate surgery	28.51	NA	10.94	2.02	NA	41.47	090
55859	.....	A	Percut/needle insert, pros	12.50	NA	5.85	0.89	NA	19.24	090
55860	.....	A	Surgical exposure, prostate	14.43	NA	6.41	1.02	NA	21.86	090
55862	.....	A	Extensive prostate surgery	18.36	NA	7.85	1.49	NA	27.70	090
55865	.....	A	Extensive prostate surgery	22.84	NA	9.27	1.63	NA	33.74	090
55866	.....	A	Laparo radical prostatectomy	30.69	NA	11.73	2.16	NA	44.58	090
55870	.....	A	Electroejaculation	2.58	1.53	1.08	0.16	4.27	3.82	000
55873	.....	A	Cryoablate prostate	19.44	NA	8.96	1.38	NA	29.78	090
55899	.....	C	Genital surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
55970	.....	N	Sex transformation, M to F	0.00	0.00	0.00	0.00	0.00	0.00	XXX
55980	.....	N	Sex transformation, F to M	0.00	0.00	0.00	0.00	0.00	0.00	XXX
56405	.....	A	I & D of vulva/perineum	1.44	1.33	1.14	0.17	2.94	2.75	010
56420	.....	A	Drainage of gland abscess	1.39	2.28	1.04	0.16	3.83	2.59	010
56440	.....	A	Surgery for vulva lesion	2.84	NA	1.71	0.34	NA	4.89	010
56441	.....	A	Lysis of labial lesion(s)	1.97	1.82	1.41	0.20	3.99	3.58	010
56501	.....	A	Destroy, vulva lesions, sim	1.53	1.79	1.24	0.18	3.50	2.95	010
56515	.....	A	Destroy vulva lesion/s compl	2.76	2.55	1.82	0.33	5.64	4.91	010
56605	.....	A	Biopsy of vulva/perineum	1.10	1.07	0.46	0.13	2.30	1.69	000
56606	.....	A	Biopsy of vulva/perineum	0.55	0.49	0.22	0.07	1.11	0.84	ZZZ
56620	.....	A	Partial removal of vulva	7.46	NA	4.80	0.90	NA	13.16	090
56625	.....	A	Complete removal of vulva	8.39	NA	5.33	1.02	NA	14.74	090
56630	.....	A	Extensive vulva surgery	12.34	NA	6.85	1.49	NA	20.68	090
56631	.....	A	Extensive vulva surgery	16.18	NA	8.83	1.95	NA	26.96	090
56632	.....	A	Extensive vulva surgery	20.26	NA	9.54	2.38	NA	32.18	090
56633	.....	A	Extensive vulva surgery	16.45	NA	8.61	1.97	NA	27.03	090
56634	.....	A	Extensive vulva surgery	17.85	NA	9.45	2.16	NA	29.46	090
56637	.....	A	Extensive vulva surgery	21.94	NA	11.09	2.60	NA	35.63	090
56640	.....	A	Extensive vulva surgery	22.14	NA	10.64	2.88	NA	35.66	090
56700	.....	A	Partial removal of hymen	2.52	NA	1.84	0.30	NA	4.66	010
56720	.....	A	Incision of hymen	0.68	NA	0.51	0.08	NA	1.27	000
56740	.....	A	Remove vagina gland lesion	4.56	NA	2.57	0.56	NA	7.69	010
56800	.....	A	Repair of vagina	3.88	NA	2.20	0.44	NA	6.52	010
56805	.....	A	Repair clitoris	18.83	NA	9.44	2.14	NA	30.41	090
56810	.....	A	Repair of perineum	4.12	NA	2.30	0.49	NA	6.91	010
56820	.....	A	Exam of vulva w/scope	1.50	1.31	0.65	0.18	2.99	2.33	000
56821	.....	A	Exam/biopsy of vulva w/scope	2.05	1.76	0.91	0.25	4.06	3.21	000
57000	.....	A	Exploration of vagina	2.97	NA	1.72	0.31	NA	5.00	010
57010	.....	A	Drainage of pelvic abscess	6.02	NA	3.81	0.71	NA	10.54	090
57020	.....	A	Drainage of pelvic fluid	1.50	0.94	0.59	0.18	2.62	2.27	000
57022	.....	A	I & d vaginal hematoma, pp	2.56	NA	1.49	0.26	NA	4.31	010
57023	.....	A	I & d vag hematoma, non-ob	4.74	NA	2.58	0.58	NA	7.90	010
57061	.....	A	Destroy vag lesions, simple	1.25	1.65	1.12	0.15	3.05	2.52	010
57065	.....	A	Destroy vag lesions, complex	2.61	2.30	1.67	0.31	5.22	4.59	010
57100	.....	A	Biopsy of vagina	1.20	1.08	0.48	0.14	2.42	1.82	000
57105	.....	A	Biopsy of vagina	1.69	1.80	1.42	0.20	3.69	3.31	010
57106	.....	A	Remove vagina wall, partial	6.35	NA	4.19	0.73	NA	11.27	090
57107	.....	A	Remove vagina tissue, part	22.97	NA	10.49	2.71	NA	36.17	090
57109	.....	A	Vaginectomy partial w/nodes	26.96	NA	11.27	3.21	NA	41.44	090
57110	.....	A	Remove vagina wall, complete	14.27	NA	7.29	1.73	NA	23.29	090
57111	.....	A	Remove vagina tissue, compl	26.96	NA	12.65	3.17	NA	42.78	090
57112	.....	A	Vaginectomy w/nodes, compl	28.96	NA	12.13	3.07	NA	44.16	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
57120	.....	A	Closure of vagina	7.40	NA	4.61	0.89	NA	12.90	090
57130	.....	A	Remove vagina lesion	2.43	2.16	1.54	0.29	4.88	4.26	010
57135	.....	A	Remove vagina lesion	2.67	2.27	1.65	0.31	5.25	4.63	010
57150	.....	A	Treat vagina infection	0.55	1.10	0.21	0.07	1.72	0.83	000
57155	.....	A	Insert uteri tandems/ovoids	6.26	NA	4.57	0.43	NA	11.26	090
57160	.....	A	Insert pessary/other device	0.89	1.01	0.34	0.10	2.00	1.33	000
57170	.....	A	Fitting of diaphragm/cap	0.91	1.48	0.33	0.11	2.50	1.35	000
57180	.....	A	Treat vaginal bleeding	1.58	2.17	1.26	0.19	3.94	3.03	010
57200	.....	A	Repair of vagina	3.93	NA	2.90	0.46	NA	7.29	090
57210	.....	A	Repair vagina/perineum	5.16	NA	3.44	0.62	NA	9.22	090
57220	.....	A	Revision of urethra	4.30	NA	3.11	0.51	NA	7.92	090
57230	.....	A	Repair of urethral lesion	5.63	NA	3.41	0.54	NA	9.58	090
57240	.....	A	Repair bladder & vagina	6.06	NA	3.82	0.62	NA	10.50	090
57250	.....	A	Repair rectum & vagina	5.52	NA	3.58	0.65	NA	9.75	090
57260	.....	A	Repair of vagina	8.26	NA	4.84	0.97	NA	14.07	090
57265	.....	A	Extensive repair of vagina	11.32	NA	6.05	1.32	NA	18.69	090
57267	.....	A	Insert mesh/pelvic flr addon	4.88	NA	1.98	0.64	NA	7.50	ZZZ
57268	.....	A	Repair of bowel bulge	6.75	NA	4.20	0.79	NA	11.74	090
57270	.....	A	Repair of bowel pouch	12.09	NA	6.26	1.42	NA	19.77	090
57280	.....	A	Suspension of vagina	15.02	NA	7.38	1.67	NA	24.07	090
57282	.....	A	Colpopexy, extraperitoneal	6.86	NA	4.51	1.02	NA	12.39	090
57283	.....	A	Colpopexy, intraperitoneal	10.84	NA	5.93	1.02	NA	17.79	090
57284	.....	A	Repair paravaginal defect	12.68	NA	7.16	1.41	NA	21.25	090
57287	.....	A	Revise/remove sling repair	10.69	NA	5.49	0.90	NA	17.08	090
57288	.....	A	Repair bladder defect	13.00	NA	5.92	1.12	NA	20.04	090
57289	.....	A	Repair bladder & vagina	11.56	NA	6.05	1.21	NA	18.82	090
57291	.....	A	Construction of vagina	7.94	NA	4.93	0.93	NA	13.80	090
57292	.....	A	Construct vagina with graft	13.07	NA	6.95	1.58	NA	21.60	090
57295	.....	A	Change vaginal graft	7.45	NA	4.44	0.91	NA	12.80	090
57300	.....	A	Repair rectum-vagina fistula	7.60	NA	4.29	0.87	NA	12.76	090
57305	.....	A	Repair rectum-vagina fistula	13.75	NA	6.28	1.72	NA	21.75	090
57307	.....	A	Fistula repair & colostomy	15.91	NA	7.01	2.01	NA	24.93	090
57308	.....	A	Fistula repair, transperine	9.93	NA	5.10	1.14	NA	16.17	090
57310	.....	A	Repair urethrovaginal lesion	6.77	NA	3.84	0.54	NA	11.15	090
57311	.....	A	Repair urethrovaginal lesion	7.97	NA	4.12	0.65	NA	12.74	090
57320	.....	A	Repair bladder-vagina lesion	8.00	NA	4.37	0.69	NA	13.06	090
57330	.....	A	Repair bladder-vagina lesion	12.33	NA	5.72	1.06	NA	19.11	090
57335	.....	A	Repair vagina	18.70	NA	9.05	1.91	NA	29.66	090
57400	.....	A	Dilation of vagina	2.27	NA	1.11	0.26	NA	3.64	000
57410	.....	A	Pelvic examination	1.75	2.02	0.89	0.18	3.95	2.82	000
57415	.....	A	Remove vaginal foreign body	2.17	NA	1.42	0.24	NA	3.83	010
57420	.....	A	Exam of vagina w/scope	1.60	1.35	0.67	0.19	3.14	2.46	000
57421	.....	A	Exam/biopsy of vag w/scope	2.20	1.85	0.96	0.27	4.32	3.43	000
57425	.....	A	Laparoscopy, surg, colpopexy	15.73	NA	6.65	1.75	NA	24.13	090
57452	.....	A	Exam of cervix w/scope	1.50	1.28	0.76	0.18	2.96	2.44	000
57454	.....	A	Bx/curett of cervix w/scope	2.33	1.64	1.15	0.28	4.25	3.76	000
57455	.....	A	Biopsy of cervix w/scope	1.99	1.72	0.87	0.24	3.95	3.10	000
57456	.....	A	Endocerv curettage w/scope	1.85	1.65	0.82	0.22	3.72	2.89	000
57460	.....	A	Bx of cervix w/scope, leep	2.83	5.86	1.38	0.34	9.03	4.55	000
57461	.....	A	Conz of cervix w/scope, leep	3.43	6.12	1.47	0.41	9.96	5.31	000
57500	.....	A	Biopsy of cervix	0.97	2.55	0.63	0.12	3.64	1.72	000
57505	.....	A	Endocervical curettage	1.14	1.46	1.10	0.14	2.74	2.38	010
57510	.....	A	Cauterization of cervix	1.90	1.56	1.04	0.23	3.69	3.17	010
57511	.....	A	Cryocautery of cervix	1.90	1.83	1.37	0.23	3.96	3.50	010
57513	.....	A	Laser surgery of cervix	1.90	1.72	1.40	0.23	3.85	3.53	010
57520	.....	A	Conization of cervix	4.03	3.94	2.88	0.49	8.46	7.40	090
57522	.....	A	Conization of cervix	3.35	3.16	2.46	0.41	6.92	6.22	090
57530	.....	A	Removal of cervix	4.78	NA	3.39	0.58	NA	8.75	090
57531	.....	A	Removal of cervix, radical	27.96	NA	13.20	3.34	NA	44.50	090
57540	.....	A	Removal of residual cervix	12.20	NA	6.25	1.49	NA	19.94	090
57545	.....	A	Remove cervix/repair pelvis	13.01	NA	6.69	1.52	NA	21.22	090
57550	.....	A	Removal of residual cervix	5.52	NA	3.83	0.67	NA	10.02	090
57555	.....	A	Remove cervix/repair vagina	8.94	NA	5.09	1.09	NA	15.12	090
57556	.....	A	Remove cervix, repair bowel	8.36	NA	4.86	0.92	NA	14.14	090
57700	.....	A	Revision of cervix	3.54	NA	3.11	0.41	NA	7.06	090
57720	.....	A	Revision of cervix	4.12	NA	3.11	0.49	NA	7.72	090
57800	.....	A	Dilation of cervical canal	0.77	0.76	0.47	0.09	1.62	1.33	000
57820	.....	A	D & c of residual cervix	1.67	1.47	1.14	0.20	3.34	3.01	010
58100	.....	A	Biopsy of uterus lining	1.53	1.32	0.72	0.18	3.03	2.43	000
58110	.....	A	Bx done w/colposcopy add-on	0.77	0.55	0.31	0.09	1.41	1.17	ZZZ
58120	.....	A	Dilation and curettage	3.27	2.31	1.88	0.39	5.97	5.54	010
58140	.....	A	Myomectomy abdom method	14.58	NA	7.12	1.81	NA	23.51	090
58145	.....	A	Myomectomy vag method	8.03	NA	4.80	0.97	NA	13.80	090
58146	.....	A	Myomectomy abdom complex	18.97	NA	9.03	2.32	NA	30.32	090
58150	.....	A	Total hysterectomy	15.22	NA	7.50	1.84	NA	24.56	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
58152	.....	A	Total hysterectomy	20.57	NA	9.88	2.47	NA	32.92	090
58180	.....	A	Partial hysterectomy	15.27	NA	7.47	1.64	NA	24.38	090
58200	.....	A	Extensive hysterectomy	21.56	NA	10.02	2.54	NA	34.12	090
58210	.....	A	Extensive hysterectomy	28.81	NA	13.23	3.37	NA	45.41	090
58240	.....	A	Removal of pelvis contents	38.33	NA	17.66	4.22	NA	60.21	090
58260	.....	A	Vaginal hysterectomy	12.96	NA	6.71	1.57	NA	21.24	090
58262	.....	A	Vag hyst including t/o	14.75	NA	7.40	1.79	NA	23.94	090
58263	.....	A	Vag hyst w/t/o & vag repair	16.04	NA	7.90	1.94	NA	25.88	090
58267	.....	A	Vag hyst w/urinary repair	17.01	NA	8.39	2.06	NA	27.46	090
58270	.....	A	Vag hyst w/enterocele repair	14.24	NA	7.08	1.73	NA	23.05	090
58275	.....	A	Hysterectomy/revise vagina	15.74	NA	7.79	1.91	NA	25.44	090
58280	.....	A	Hysterectomy/revise vagina	16.98	NA	8.27	2.06	NA	27.31	090
58285	.....	A	Extensive hysterectomy	22.23	NA	9.97	2.70	NA	34.90	090
58290	.....	A	Vag hyst complex	18.97	NA	9.15	2.29	NA	30.41	090
58291	.....	A	Vag hyst incl t/o, complex	20.76	NA	9.90	2.52	NA	33.18	090
58292	.....	A	Vag hyst t/o & repair, compl	22.05	NA	10.39	2.67	NA	35.11	090
58293	.....	A	Vag hyst w/uro repair, compl	23.03	NA	10.68	2.78	NA	36.49	090
58294	.....	A	Vag hyst w/enterocele, compl	20.25	NA	9.58	2.39	NA	32.22	090
58300	.....	N	Insert intrauterine device	+1.01	1.42	0.38	0.12	2.55	1.51	XXX
58301	.....	A	Remove intrauterine device	1.27	1.32	0.48	0.15	2.74	1.90	000
58321	.....	A	Artificial insemination	0.92	1.15	0.37	0.10	2.17	1.39	000
58322	.....	A	Artificial insemination	1.10	1.20	0.42	0.13	2.43	1.65	000
58323	.....	A	Sperm washing	0.23	0.53	0.09	0.03	0.79	0.35	000
58340	.....	A	Catheter for hysterography	0.88	3.17	0.65	0.09	4.14	1.62	000
58345	.....	A	Reopen fallopian tube	4.65	NA	2.44	0.41	NA	7.50	010
58346	.....	A	Insert heyman uteri capsule	6.74	NA	3.93	0.56	NA	11.23	090
58350	.....	A	Reopen fallopian tube	1.01	1.49	0.92	0.12	2.62	2.05	010
58353	.....	A	Endometr ablate, thermal	3.55	35.76	2.06	0.43	39.74	6.04	010
58356	.....	A	Endometrial cryoablation	6.36	61.61	2.70	0.82	68.79	9.88	010
58400	.....	A	Suspension of uterus	6.35	NA	3.94	0.75	NA	11.04	090
58410	.....	A	Suspension of uterus	12.71	NA	6.45	1.45	NA	20.61	090
58520	.....	A	Repair of ruptured uterus	11.90	NA	6.05	1.47	NA	19.42	090
58540	.....	A	Revision of uterus	14.62	NA	6.97	1.78	NA	23.37	090
58545	.....	A	Laparoscopic myomectomy	14.58	NA	7.20	1.77	NA	23.55	090
58546	.....	A	Laparo-myomectomy, complex	18.97	NA	8.94	2.30	NA	30.21	090
58550	.....	A	Laparo-asst vag hysterectomy	14.17	NA	7.31	1.72	NA	23.20	090
58552	.....	A	Laparo-vag hyst incl t/o	15.98	NA	8.03	1.72	NA	25.73	090
58553	.....	A	Laparo-vag hyst, complex	18.97	NA	8.94	2.30	NA	30.21	090
58554	.....	A	Laparo-vag hyst w/t/o, compl	21.97	NA	10.42	2.27	NA	34.66	090
58555	.....	A	Hysteroscopy, dx, sep proc	3.33	2.20	1.55	0.40	5.93	5.28	000
58558	.....	A	Hysteroscopy, biopsy	4.74	NA	2.18	0.57	NA	7.49	000
58559	.....	A	Hysteroscopy, lysis	6.16	NA	2.74	0.74	NA	9.64	000
58560	.....	A	Hysteroscopy, resect septum	6.99	NA	3.09	0.84	NA	10.92	000
58561	.....	A	Hysteroscopy, remove myoma	9.99	NA	4.29	1.21	NA	15.49	000
58562	.....	A	Hysteroscopy, remove fb	5.20	NA	2.36	0.63	NA	8.19	000
58563	.....	A	Hysteroscopy, ablation	6.16	56.35	2.76	0.74	63.25	9.66	000
58565	.....	A	Hysteroscopy, sterilization	7.02	49.70	3.91	1.19	57.91	12.12	090
58578	.....	C	Laparo proc, uterus	0.00	0.00	0.00	0.00	0.00	0.00	YYY
58579	.....	C	Hysteroscope procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
58600	.....	A	Division of fallopian tube	5.59	NA	3.34	0.66	NA	9.59	090
58605	.....	A	Division of fallopian tube	4.99	NA	3.12	0.59	NA	8.70	090
58611	.....	A	Ligate oviduct(s) add-on	1.45	NA	0.57	0.18	NA	2.20	ZZZ
58615	.....	A	Occlude fallopian tube(s)	3.89	NA	2.71	0.47	NA	7.07	010
58660	.....	A	Laparoscopy, lysis	11.27	NA	5.27	1.40	NA	17.94	090
58661	.....	A	Laparoscopy, remove adnexa	11.03	NA	5.13	1.34	NA	17.50	010
58662	.....	A	Laparoscopy, excise lesions	11.77	NA	5.80	1.43	NA	19.00	090
58670	.....	A	Laparoscopy, tubal cautery	5.59	NA	3.28	0.67	NA	9.54	090
58671	.....	A	Laparoscopy, tubal block	5.59	NA	3.28	0.68	NA	9.55	090
58672	.....	A	Laparoscopy, fimbrioplasty	12.86	NA	6.20	1.60	NA	20.66	090
58673	.....	A	Laparoscopy, salpingostomy	13.72	NA	6.59	1.69	NA	22.00	090
58679	.....	C	Laparo proc, oviduct-ovary	0.00	0.00	0.00	0.00	0.00	0.00	YYY
58700	.....	A	Removal of fallopian tube	12.03	NA	6.00	1.51	NA	19.54	090
58720	.....	A	Removal of ovary/tube(s)	11.34	NA	5.79	1.39	NA	18.52	090
58740	.....	A	Revise fallopian tube(s)	13.98	NA	7.15	1.71	NA	22.84	090
58750	.....	A	Repair oviduct	14.82	NA	7.38	1.84	NA	24.04	090
58752	.....	A	Revise ovarian tube(s)	14.82	NA	6.96	1.80	NA	23.58	090
58760	.....	A	Remove tubal obstruction	13.11	NA	6.73	1.79	NA	21.63	090
58770	.....	A	Create new tubal opening	13.95	NA	6.92	1.73	NA	22.60	090
58800	.....	A	Drainage of ovarian cyst(s)	4.13	3.65	2.91	0.43	8.21	7.47	090
58805	.....	A	Drainage of ovarian cyst(s)	5.87	NA	3.51	0.69	NA	10.07	090
58820	.....	A	Drain ovary abscess, open	4.21	NA	3.30	0.52	NA	8.03	090
58822	.....	A	Drain ovary abscess, percut	10.11	NA	5.23	1.16	NA	16.50	090
58823	.....	A	Drain pelvic abscess, percut	3.37	21.38	1.12	0.24	24.99	4.73	000
58825	.....	A	Transposition, ovary(s)	10.96	NA	5.81	1.32	NA	18.09	090
58900	.....	A	Biopsy of ovary(s)	5.98	NA	3.58	0.69	NA	10.25	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
58920	.....	A	Partial removal of ovary(s)	11.34	NA	5.59	1.43	NA	18.36	090
58925	.....	A	Removal of ovarian cyst(s)	11.34	NA	5.70	1.41	NA	18.45	090
58940	.....	A	Removal of ovary(s)	7.28	NA	4.11	0.91	NA	12.30	090
58943	.....	A	Removal of ovary(s)	18.40	NA	8.67	2.22	NA	29.29	090
58950	.....	A	Resect ovarian malignancy	16.90	NA	8.42	2.04	NA	27.36	090
58951	.....	A	Resect ovarian malignancy	22.35	NA	10.47	2.63	NA	35.45	090
58952	.....	A	Resect ovarian malignancy	24.97	NA	11.78	3.02	NA	39.77	090
58953	.....	A	Tah, rad dissect for debulk	31.95	NA	14.58	3.83	NA	50.36	090
58954	.....	A	Tah rad debulk/lymph remove	34.95	NA	15.75	4.17	NA	54.87	090
58956	.....	A	Bso, omentectomy w/tah	20.78	NA	10.34	4.00	NA	35.12	090
58960	.....	A	Exploration of abdomen	14.63	NA	7.37	1.79	NA	23.79	090
58970	.....	A	Retrieval of oocyte	3.52	2.32	1.49	0.43	6.27	5.44	000
58974	.....	C	Transfer of embryo	0.00	0.00	0.00	0.00	0.00	0.00	000
58976	.....	A	Transfer of embryo	3.82	2.69	1.83	0.47	6.98	6.12	000
58999	.....	C	Genital surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
59000	.....	A	Amniocentesis, diagnostic	1.30	2.08	0.67	0.31	3.69	2.28	000
59001	.....	A	Amniocentesis, therapeutic	3.00	NA	1.41	0.71	NA	5.12	000
59012	.....	A	Fetal cord puncture, prenatal	3.44	NA	1.54	0.82	NA	5.80	000
59015	.....	A	Chorion biopsy	2.20	1.55	1.04	0.52	4.27	3.76	000
59020	26	A	Fetal contract stress test	0.66	0.26	0.26	0.16	1.08	1.08	000
59020	TC	A	Fetal contract stress test	0.00	0.52	NA	0.10	0.62	NA	000
59020	.....	A	Fetal contract stress test	0.66	0.78	NA	0.26	1.70	NA	000
59025	26	A	Fetal non-stress test	0.53	0.21	0.21	0.13	0.87	0.87	000
59025	TC	A	Fetal non-stress test	0.00	0.23	NA	0.02	0.25	NA	000
59025	.....	A	Fetal non-stress test	0.53	0.44	NA	0.15	1.12	NA	000
59030	.....	A	Fetal scalp blood sample	1.99	NA	0.77	0.47	NA	3.23	000
59050	.....	A	Fetal monitor w/report	0.89	NA	0.35	0.21	NA	1.45	XXX
59051	.....	A	Fetal monitor/interpret only	0.74	NA	0.29	0.17	NA	1.20	XXX
59070	.....	A	Transabdom amnioinfus w/us	5.24	5.16	2.32	0.28	10.68	7.84	000
59072	.....	A	Umbilical cord occlud w/us	8.99	NA	3.13	0.16	NA	12.28	000
59074	.....	A	Fetal fluid drainage w/us	5.24	4.58	2.32	0.28	10.10	7.84	000
59076	.....	A	Fetal shunt placement, w/us	8.99	NA	3.13	0.16	NA	12.28	000
59100	.....	A	Remove uterus lesion	12.33	NA	6.47	2.94	NA	21.74	090
59120	.....	A	Treat ectopic pregnancy	11.47	NA	6.26	2.72	NA	20.45	090
59121	.....	A	Treat ectopic pregnancy	11.65	NA	6.34	2.78	NA	20.77	090
59130	.....	A	Treat ectopic pregnancy	14.20	NA	4.80	3.38	NA	22.38	090
59135	.....	A	Treat ectopic pregnancy	13.86	NA	7.24	3.30	NA	24.40	090
59136	.....	A	Treat ectopic pregnancy	13.16	NA	6.62	3.13	NA	22.91	090
59140	.....	A	Treat ectopic pregnancy	5.45	2.22	2.22	1.29	8.96	8.96	090
59150	.....	A	Treat ectopic pregnancy	11.65	NA	6.01	2.78	NA	20.44	090
59151	.....	A	Treat ectopic pregnancy	11.47	NA	6.07	2.73	NA	20.27	090
59160	.....	A	D & c after delivery	2.71	3.30	2.14	0.64	6.65	5.49	010
59200	.....	A	Insert cervical dilator	0.79	1.19	0.30	0.19	2.17	1.28	000
59300	.....	A	Episiotomy or vaginal repair	2.41	2.18	0.96	0.57	5.16	3.94	000
59320	.....	A	Revision of cervix	2.48	NA	1.24	0.59	NA	4.31	000
59325	.....	A	Revision of cervix	4.06	NA	1.90	0.88	NA	6.84	000
59350	.....	A	Repair of uterus	4.94	NA	1.88	1.17	NA	7.99	000
59400	.....	A	Obstetrical care	23.03	NA	15.36	5.48	NA	43.87	MMM
59409	.....	A	Obstetrical care	13.48	NA	5.32	3.21	NA	22.01	MMM
59410	.....	A	Obstetrical care	14.76	NA	6.32	3.51	NA	24.59	MMM
59412	.....	A	Antepartum manipulation	1.71	NA	0.81	0.40	NA	2.92	MMM
59414	.....	A	Deliver placenta	1.61	NA	0.64	0.38	NA	2.63	MMM
59425	.....	A	Antepartum care only	4.80	4.21	1.86	1.14	10.15	7.80	MMM
59426	.....	A	Antepartum care only	8.27	7.56	3.23	1.97	17.80	13.47	MMM
59430	.....	A	Care after delivery	2.13	1.23	0.94	0.50	3.86	3.57	MMM
59510	.....	A	Cesarean delivery	26.18	NA	17.31	6.23	NA	49.72	MMM
59514	.....	A	Cesarean delivery only	15.95	NA	6.23	3.79	NA	25.97	MMM
59515	.....	A	Cesarean delivery	17.34	NA	7.85	4.12	NA	29.31	MMM
59525	.....	A	Remove uterus after cesarean	8.53	NA	3.31	1.94	NA	13.78	ZZZ
59610	.....	A	Vbac delivery	24.58	NA	15.91	5.85	NA	46.34	MMM
59612	.....	A	Vbac delivery only	15.04	NA	6.07	3.58	NA	24.69	MMM
59614	.....	A	Vbac care after delivery	16.32	NA	6.95	3.88	NA	27.15	MMM
59618	.....	A	Attempted vbac delivery	27.74	NA	18.28	6.59	NA	52.61	MMM
59620	.....	A	Attempted vbac delivery only	17.50	NA	6.78	4.16	NA	28.44	MMM
59622	.....	A	Attempted vbac after care	18.90	NA	8.66	4.49	NA	32.05	MMM
59812	.....	A	Treatment of miscarriage	4.00	NA	2.55	0.95	NA	7.50	090
59820	.....	A	Care of miscarriage	4.00	4.43	3.57	0.95	9.38	8.52	090
59821	.....	A	Treatment of miscarriage	4.46	4.28	3.41	1.06	9.80	8.93	090
59830	.....	A	Treat uterus infection	6.10	NA	3.99	1.44	NA	11.53	090
59840	.....	R	Abortion	3.01	NA	2.13	0.71	NA	5.85	010
59841	.....	R	Abortion	5.23	3.50	2.98	1.24	9.97	9.45	010
59850	.....	R	Abortion	5.90	NA	3.26	1.28	NA	10.44	090
59851	.....	R	Abortion	5.92	NA	3.75	1.28	NA	10.95	090
59852	.....	R	Abortion	8.23	NA	5.05	1.80	NA	15.08	090
59855	.....	R	Abortion	6.11	NA	3.55	1.45	NA	11.11	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
59856	.....	R	Abortion	7.47	NA	4.07	1.78	NA	13.32	090
59857	.....	R	Abortion	9.28	NA	4.72	2.01	NA	16.01	090
59866	.....	R	Abortion (mpr)	3.99	NA	1.90	0.87	NA	6.76	000
59870	.....	A	Evacuate mole of uterus	6.00	NA	4.49	1.42	NA	11.91	090
59871	.....	A	Remove cerclage suture	2.13	1.75	1.13	0.50	4.38	3.76	000
59897	.....	C	Fetal invas px w/us	0.00	0.00	0.00	0.00	0.00	0.00	YYY
59898	.....	C	Laparo proc, ob care/deliver	0.00	0.00	0.00	0.00	0.00	0.00	YYY
59899	.....	C	Maternity care procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
60000	.....	A	Drain thyroid/tongue cyst	1.76	1.93	1.71	0.15	3.84	3.62	010
60001	.....	A	Aspirate/inject thyriod cyst	0.97	1.41	0.33	0.07	2.45	1.37	000
60100	.....	A	Biopsy of thyroid	1.56	1.40	0.53	0.10	3.06	2.19	000
60200	.....	A	Remove thyroid lesion	9.54	NA	6.00	1.01	NA	16.55	090
60210	.....	A	Partial thyroid excision	10.86	NA	5.65	1.23	NA	17.74	090
60212	.....	A	Partial thyroid excision	16.01	NA	7.69	1.94	NA	25.64	090
60220	.....	A	Partial removal of thyroid	11.88	NA	6.16	1.32	NA	19.36	090
60225	.....	A	Partial removal of thyroid	14.17	NA	7.42	1.64	NA	23.23	090
60240	.....	A	Removal of thyroid	16.04	NA	7.60	1.85	NA	25.49	090
60252	.....	A	Removal of thyroid	20.54	NA	10.12	2.29	NA	32.95	090
60254	.....	A	Extensive thyroid surgery	26.95	NA	14.18	2.60	NA	43.73	090
60260	.....	A	Repeat thyroid surgery	17.44	NA	8.67	1.93	NA	28.04	090
60270	.....	A	Removal of thyroid	20.24	NA	10.48	2.32	NA	33.04	090
60271	.....	A	Removal of thyroid	16.80	NA	8.60	1.74	NA	27.14	090
60280	.....	A	Remove thyroid duct lesion	5.86	NA	4.67	0.54	NA	11.07	090
60281	.....	A	Remove thyroid duct lesion	8.52	NA	5.85	0.73	NA	15.10	090
60500	.....	A	Explore parathyroid glands	16.21	NA	7.42	2.00	NA	25.63	090
60502	.....	A	Re-explore parathyroids	20.32	NA	9.38	2.53	NA	32.23	090
60505	.....	A	Explore parathyroid glands	21.46	NA	10.95	2.64	NA	35.05	090
60512	.....	A	Autotransplant parathyroid	4.44	NA	1.62	0.53	NA	6.59	ZZZ
60520	.....	A	Removal of thymus gland	16.78	NA	8.31	2.19	NA	27.28	090
60521	.....	A	Removal of thymus gland	18.84	NA	9.57	2.81	NA	31.22	090
60522	.....	A	Removal of thymus gland	23.06	NA	11.29	3.26	NA	37.61	090
60540	.....	A	Explore adrenal gland	17.00	NA	7.60	1.74	NA	26.34	090
60545	.....	A	Explore adrenal gland	19.85	NA	8.55	2.07	NA	30.47	090
60600	.....	A	Remove carotid body lesion	17.90	NA	10.99	2.19	NA	31.08	090
60605	.....	A	Remove carotid body lesion	20.21	NA	12.29	2.49	NA	34.99	090
60650	.....	A	Laparoscopy adrenalectomy	19.97	NA	8.00	2.28	NA	30.25	090
60659	.....	C	Laparo proc, endocrine	0.00	0.00	0.00	0.00	0.00	0.00	YYY
60699	.....	C	Endocrine surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
61000	.....	A	Remove cranial cavity fluid	1.58	NA	0.95	0.13	NA	2.66	000
61001	.....	A	Remove cranial cavity fluid	1.49	NA	1.06	0.16	NA	2.71	000
61020	.....	A	Remove brain cavity fluid	1.51	NA	1.34	0.34	NA	3.19	000
61026	.....	A	Injection into brain canal	1.69	NA	1.39	0.33	NA	3.41	000
61050	.....	A	Remove brain canal fluid	1.51	NA	1.27	0.11	NA	2.89	000
61055	.....	A	Injection into brain canal	2.10	NA	1.42	0.17	NA	3.69	000
61070	.....	A	Brain canal shunt procedure	0.89	NA	1.01	0.17	NA	2.07	000
61105	.....	A	Twist drill hole	5.13	NA	3.94	1.32	NA	10.39	090
61107	.....	A	Drill skull for implantation	4.99	NA	2.54	1.29	NA	8.82	000
61108	.....	A	Drill skull for drainage	10.17	NA	7.16	2.63	NA	19.96	090
61120	.....	A	Burr hole for puncture	8.75	NA	6.01	2.09	NA	16.85	090
61140	.....	A	Pierce skull for biopsy	15.88	NA	9.91	4.11	NA	29.90	090
61150	.....	A	Pierce skull for drainage	17.54	NA	10.40	4.31	NA	32.25	090
61151	.....	A	Pierce skull for drainage	12.40	NA	7.83	3.00	NA	23.23	090
61154	.....	A	Pierce skull & remove clot	14.97	NA	9.51	4.20	NA	28.68	090
61156	.....	A	Pierce skull for drainage	16.30	NA	9.86	4.22	NA	30.38	090
61210	.....	A	Pierce skull, implant device	5.83	NA	2.92	1.50	NA	10.25	000
61215	.....	A	Insert brain-fluid device	4.88	NA	4.01	1.26	NA	10.15	090
61250	.....	A	Pierce skull & explore	10.40	NA	6.87	2.76	NA	20.03	090
61253	.....	A	Pierce skull & explore	12.34	NA	7.74	2.61	NA	22.69	090
61304	.....	A	Open skull for exploration	21.93	NA	12.87	5.61	NA	40.41	090
61305	.....	A	Open skull for exploration	26.57	NA	15.35	6.07	NA	47.99	090
61312	.....	A	Open skull for drainage	24.53	NA	15.08	6.34	NA	45.95	090
61313	.....	A	Open skull for drainage	24.89	NA	14.84	6.43	NA	46.16	090
61314	.....	A	Open skull for drainage	24.19	NA	13.07	6.26	NA	43.52	090
61315	.....	A	Open skull for drainage	27.64	NA	16.06	7.14	NA	50.84	090
61316	.....	A	Implt cran bone flap to abdo	1.39	NA	0.60	0.35	NA	2.34	ZZZ
61320	.....	A	Open skull for drainage	25.58	NA	14.79	6.60	NA	46.97	090
61321	.....	A	Open skull for drainage	28.46	NA	16.17	7.12	NA	51.75	090
61322	.....	A	Decompressive craniotomy	29.46	NA	15.71	7.61	NA	52.78	090
61323	.....	A	Decompressive lobectomy	30.95	NA	16.13	8.01	NA	55.09	090
61330	.....	A	Decompress eye socket	23.29	NA	13.76	2.31	NA	39.36	090
61332	.....	A	Explore/biopsy eye socket	27.24	NA	15.64	4.82	NA	47.70	090
61333	.....	A	Explore orbit/remove lesion	27.91	NA	15.62	3.91	NA	47.44	090
61334	.....	A	Explore orbit/remove object	18.24	NA	10.66	1.74	NA	30.64	090
61340	.....	A	Subtemporal decompression	18.63	NA	11.15	4.83	NA	34.61	090
61343	.....	A	Incise skull (press relief)	29.73	NA	16.85	7.62	NA	54.20	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
61345	.....	A	Relieve cranial pressure	27.16	NA	15.43	7.02	NA	49.61	090
61440	.....	A	Incise skull for surgery	26.59	NA	14.24	6.88	NA	47.71	090
61450	.....	A	Incise skull for surgery	25.91	NA	14.32	5.77	NA	46.00	090
61458	.....	A	Incise skull for brain wound	27.25	NA	15.55	7.01	NA	49.81	090
61460	.....	A	Incise skull for surgery	28.35	NA	16.46	6.02	NA	50.83	090
61470	.....	A	Incise skull for surgery	26.02	NA	13.89	5.88	NA	45.79	090
61480	.....	A	Incise skull for surgery	26.45	NA	15.31	6.71	NA	48.47	090
61490	.....	A	Incise skull for surgery	25.62	NA	14.36	6.90	NA	46.88	090
61500	.....	A	Removal of skull lesion	17.89	NA	10.83	4.10	NA	32.82	090
61501	.....	A	Remove infected skull bone	14.82	NA	9.23	3.21	NA	27.26	090
61510	.....	A	Removal of brain lesion	28.41	NA	16.74	7.33	NA	52.48	090
61512	.....	A	Remove brain lining lesion	35.04	NA	19.73	9.05	NA	63.82	090
61514	.....	A	Removal of brain abscess	25.22	NA	14.47	6.52	NA	46.21	090
61516	.....	A	Removal of brain lesion	24.57	NA	14.30	6.33	NA	45.20	090
61517	.....	A	Implt brain chemotx add-on	1.38	NA	0.64	0.35	NA	2.37	ZZZ
61518	.....	A	Removal of brain lesion	37.26	NA	21.15	9.62	NA	68.03	090
61519	.....	A	Remove brain lining lesion	41.33	NA	22.71	10.60	NA	74.64	090
61520	.....	A	Removal of brain lesion	54.76	NA	30.41	11.18	NA	96.35	090
61521	.....	A	Removal of brain lesion	44.41	NA	24.28	11.36	NA	80.05	090
61522	.....	A	Removal of brain abscess	29.41	NA	16.46	7.60	NA	53.47	090
61524	.....	A	Removal of brain lesion	27.82	NA	15.71	7.14	NA	50.67	090
61526	.....	A	Removal of brain lesion	52.09	NA	29.57	7.05	NA	88.71	090
61530	.....	A	Removal of brain lesion	43.79	NA	25.12	6.13	NA	75.04	090
61531	.....	A	Implant brain electrodes	14.61	NA	9.15	3.78	NA	27.54	090
61533	.....	A	Implant brain electrodes	19.68	NA	11.56	5.10	NA	36.34	090
61534	.....	A	Removal of brain lesion	20.94	NA	12.12	5.42	NA	38.48	090
61535	.....	A	Remove brain electrodes	11.61	NA	7.44	3.01	NA	22.06	090
61536	.....	A	Removal of brain lesion	35.47	NA	19.84	9.18	NA	64.49	090
61537	.....	A	Removal of brain tissue	24.96	NA	14.78	6.92	NA	46.66	090
61538	.....	A	Removal of brain tissue	26.77	NA	15.35	6.92	NA	49.04	090
61539	.....	A	Removal of brain tissue	32.03	NA	17.81	8.30	NA	58.14	090
61540	.....	A	Removal of brain tissue	29.96	NA	17.29	8.30	NA	55.55	090
61541	.....	A	Incision of brain tissue	28.81	NA	16.25	6.58	NA	51.64	090
61542	.....	A	Removal of brain tissue	30.97	NA	17.87	8.01	NA	56.85	090
61543	.....	A	Removal of brain tissue	29.18	NA	16.43	7.54	NA	53.15	090
61544	.....	A	Remove & treat brain lesion	25.46	NA	13.86	5.95	NA	45.27	090
61545	.....	A	Excision of brain tumor	43.73	NA	24.28	10.60	NA	78.61	090
61546	.....	A	Removal of pituitary gland	31.25	NA	17.54	7.65	NA	56.44	090
61548	.....	A	Removal of pituitary gland	21.50	NA	12.82	3.42	NA	37.74	090
61550	.....	A	Release of skull seams	14.63	NA	6.95	0.98	NA	22.56	090
61552	.....	A	Release of skull seams	19.53	NA	9.14	1.06	NA	29.73	090
61556	.....	A	Incise skull/sutures	22.23	NA	11.39	4.64	NA	38.26	090
61557	.....	A	Incise skull/sutures	22.35	NA	13.66	5.78	NA	41.79	090
61558	.....	A	Excision of skull/sutures	25.54	NA	14.23	1.36	NA	41.13	090
61559	.....	A	Excision of skull/sutures	32.74	NA	19.37	8.48	NA	60.59	090
61563	.....	A	Excision of skull tumor	26.79	NA	15.28	5.15	NA	47.22	090
61564	.....	A	Excision of skull tumor	33.78	NA	18.33	8.75	NA	60.86	090
61566	.....	A	Removal of brain tissue	30.95	NA	17.82	6.92	NA	55.69	090
61567	.....	A	Incision of brain tissue	35.45	NA	20.73	6.52	NA	62.70	090
61570	.....	A	Remove foreign body, brain	24.56	NA	13.95	5.86	NA	44.37	090
61571	.....	A	Incise skull for brain wound	26.35	NA	15.18	6.77	NA	48.30	090
61575	.....	A	Skull base/brainstem surgery	34.31	NA	19.69	5.32	NA	59.32	090
61576	.....	A	Skull base/brainstem surgery	52.35	NA	34.83	5.56	NA	92.74	090
61580	.....	A	Craniofacial approach, skull	30.30	NA	25.65	3.36	NA	59.31	090
61581	.....	A	Craniofacial approach, skull	34.55	NA	23.51	3.91	NA	61.97	090
61582	.....	A	Craniofacial approach, skull	31.61	NA	27.38	7.19	NA	66.18	090
61583	.....	A	Craniofacial approach, skull	36.16	NA	25.18	9.18	NA	70.52	090
61584	.....	A	Orbitocranial approach/skull	34.60	NA	24.59	8.16	NA	67.35	090
61585	.....	A	Orbitocranial approach/skull	38.55	NA	26.57	7.01	NA	72.13	090
61586	.....	A	Resect nasopharynx, skull	25.06	NA	22.65	4.36	NA	52.07	090
61590	.....	A	Infratemporal approach/skull	41.72	NA	28.70	5.29	NA	75.71	090
61591	.....	A	Infratemporal approach/skull	43.61	NA	29.61	5.64	NA	78.86	090
61592	.....	A	Orbitocranial approach/skull	39.58	NA	26.58	10.04	NA	76.20	090
61595	.....	A	Transtemporal approach/skull	29.53	NA	22.41	3.97	NA	55.91	090
61596	.....	A	Transcochlear approach/skull	35.58	NA	24.51	3.39	NA	63.48	090
61597	.....	A	Transcondylar approach/skull	37.90	NA	23.06	8.81	NA	69.77	090
61598	.....	A	Transpetrosal approach/skull	33.36	NA	23.30	5.68	NA	62.34	090
61600	.....	A	Resect/excise cranial lesion	25.81	NA	19.83	3.78	NA	49.42	090
61601	.....	A	Resect/excise cranial lesion	27.85	NA	20.55	6.61	NA	55.01	090
61605	.....	A	Resect/excise cranial lesion	29.29	NA	22.02	2.85	NA	54.16	090
61606	.....	A	Resect/excise cranial lesion	38.77	NA	25.22	8.94	NA	72.93	090
61607	.....	A	Resect/excise cranial lesion	36.22	NA	23.85	6.88	NA	66.95	090
61608	.....	A	Resect/excise cranial lesion	42.04	NA	26.66	10.72	NA	79.42	090
61609	.....	A	Transect artery, sinus	9.88	NA	4.86	2.55	NA	17.29	ZZZ
61610	.....	A	Transect artery, sinus	29.63	NA	13.18	7.66	NA	50.47	ZZZ

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
61611	.....	A	Transect artery, sinus	7.41	NA	3.83	1.88	NA	13.12	ZZZ
61612	.....	A	Transect artery, sinus	27.84	NA	13.35	4.30	NA	45.49	ZZZ
61613	.....	A	Remove aneurysm, sinus	40.80	NA	26.34	8.42	NA	75.56	090
61615	.....	A	Resect/excise lesion, skull	32.02	NA	22.79	4.72	NA	59.53	090
61616	.....	A	Resect/excise lesion, skull	43.27	NA	28.73	8.24	NA	80.24	090
61618	.....	A	Repair dura	16.96	NA	10.47	3.71	NA	31.14	090
61619	.....	A	Repair dura	20.68	NA	12.28	3.94	NA	36.90	090
61623	.....	A	Endovasc tempory vessel occl	9.95	NA	4.09	1.05	NA	15.09	000
61624	.....	A	Transcath occlusion, cns	20.12	NA	6.91	1.95	NA	28.98	000
61626	.....	A	Transcath occlusion, non-cns	16.60	NA	5.53	1.24	NA	23.37	000
61630	.....	N	Intracranial angioplasty	0.00	0.00	0.00	0.00	0.00	0.00	090
61635	.....	N	Intracran angioplsty w/stent	0.00	0.00	0.00	0.00	0.00	0.00	090
61640	.....	N	Dilate ic vasospasm, init	0.00	0.00	0.00	0.00	0.00	0.00	000
61641	.....	N	Dilate ic vasospasm add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
61642	.....	N	Dilate ic vasospasm add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
61680	.....	A	Intracranial vessel surgery	30.66	NA	17.48	7.93	NA	56.07	090
61682	.....	A	Intracranial vessel surgery	61.48	NA	32.30	15.85	NA	109.63	090
61684	.....	A	Intracranial vessel surgery	39.75	NA	22.06	10.28	NA	72.09	090
61686	.....	A	Intracranial vessel surgery	64.39	NA	34.82	16.66	NA	115.87	090
61690	.....	A	Intracranial vessel surgery	29.27	NA	16.77	6.92	NA	52.96	090
61692	.....	A	Intracranial vessel surgery	51.79	NA	27.55	13.39	NA	92.73	090
61697	.....	A	Brain aneurysm repr, complx	50.44	NA	28.09	12.81	NA	91.34	090
61698	.....	A	Brain aneurysm repr, complx	48.34	NA	26.77	12.50	NA	87.61	090
61700	.....	A	Brain aneurysm repr, simple	50.44	NA	27.88	12.98	NA	91.30	090
61702	.....	A	Inner skull vessel surgery	48.34	NA	26.11	10.76	NA	85.21	090
61703	.....	A	Clamp neck artery	17.44	NA	10.49	4.05	NA	31.98	090
61705	.....	A	Revise circulation to head	36.15	NA	19.31	8.84	NA	64.30	090
61708	.....	A	Revise circulation to head	35.25	NA	15.19	2.50	NA	52.94	090
61710	.....	A	Revise circulation to head	29.63	NA	13.68	4.51	NA	47.82	090
61711	.....	A	Fusion of skull arteries	36.28	NA	19.86	9.39	NA	65.53	090
61720	.....	A	Incise skull/brain surgery	16.74	NA	10.00	2.78	NA	29.52	090
61735	.....	A	Incise skull/brain surgery	20.40	NA	12.20	2.72	NA	35.32	090
61750	.....	A	Incise skull/brain biopsy	18.17	NA	10.64	4.71	NA	33.52	090
61751	.....	A	Brain biopsy w/ct/mr guide	17.59	NA	10.85	4.55	NA	32.99	090
61760	.....	A	Implant brain electrodes	22.24	NA	8.74	5.40	NA	36.38	090
61770	.....	A	Incise skull for treatment	21.41	NA	12.29	3.54	NA	37.24	090
61790	.....	A	Treat trigeminal nerve	10.84	NA	5.93	2.81	NA	19.58	090
61791	.....	A	Treat trigeminal tract	14.59	NA	8.94	3.39	NA	26.92	090
61793	.....	A	Focus radiation beam	17.21	NA	10.15	4.45	NA	31.81	090
61795	.....	A	Brain surgery using computer	4.03	NA	2.04	0.79	NA	6.86	ZZZ
61850	.....	A	Implant neuroelectrodes	12.37	NA	7.69	3.21	NA	23.27	090
61860	.....	A	Implant neuroelectrodes	20.84	NA	12.09	4.94	NA	37.87	090
61863	.....	A	Implant neuroelectrode	18.97	NA	11.80	5.41	NA	36.18	090
61864	.....	A	Implant neuroelectrde, addl	4.49	NA	2.29	5.41	NA	12.19	ZZZ
61867	.....	A	Implant neuroelectrode	31.29	NA	18.07	5.41	NA	54.77	090
61868	.....	A	Implant neuroelectrde, add'l	7.91	NA	4.02	5.41	NA	17.34	ZZZ
61870	.....	A	Implant neuroelectrodes	14.92	NA	9.73	3.86	NA	28.51	090
61875	.....	A	Implant neuroelectrodes	15.04	NA	8.59	2.94	NA	26.57	090
61880	.....	A	Revise/remove neuroelectrode	6.28	NA	4.58	1.66	NA	12.52	090
61885	.....	A	Insrt/redo neurostim 1 array	5.84	NA	5.32	1.59	NA	12.75	090
61886	.....	A	Implant neurostim arrays	7.99	NA	6.37	1.96	NA	16.32	090
61888	.....	A	Revise/remove neuroreceiver	5.06	NA	3.68	1.33	NA	10.07	010
62000	.....	A	Treat skull fracture	12.51	NA	5.53	1.06	NA	19.10	090
62005	.....	A	Treat skull fracture	16.15	NA	8.82	3.86	NA	28.83	090
62010	.....	A	Treatment of head injury	19.78	NA	11.74	5.12	NA	36.64	090
62100	.....	A	Repair brain fluid leakage	22.00	NA	12.82	4.83	NA	39.65	090
62115	.....	A	Reduction of skull defect	21.63	NA	11.67	5.49	NA	38.79	090
62116	.....	A	Reduction of skull defect	23.55	NA	13.40	6.09	NA	43.04	090
62117	.....	A	Reduction of skull defect	26.56	NA	15.41	4.52	NA	46.49	090
62120	.....	A	Repair skull cavity lesion	23.31	NA	18.53	2.99	NA	44.83	090
62121	.....	A	Incise skull repair	21.55	NA	15.49	4.16	NA	41.20	090
62140	.....	A	Repair of skull defect	13.49	NA	8.34	3.46	NA	25.29	090
62141	.....	A	Repair of skull defect	14.89	NA	9.07	3.75	NA	27.71	090
62142	.....	A	Remove skull plate/flap	10.77	NA	7.01	2.72	NA	20.50	090
62143	.....	A	Replace skull plate/flap	13.03	NA	8.06	3.36	NA	24.45	090
62145	.....	A	Repair of skull & brain	18.79	NA	10.92	4.49	NA	34.20	090
62146	.....	A	Repair of skull with graft	16.10	NA	9.66	3.61	NA	29.37	090
62147	.....	A	Repair of skull with graft	19.31	NA	11.33	4.31	NA	34.95	090
62148	.....	A	Retr bone flap to fix skull	2.00	NA	0.86	0.48	NA	3.34	ZZZ
62160	.....	A	Neuroendoscopy add-on	3.00	NA	1.53	0.77	NA	5.30	ZZZ
62161	.....	A	Dissect brain w/scope	19.97	NA	12.13	5.17	NA	37.27	090
62162	.....	A	Remove colloid cyst w/scope	25.21	NA	14.89	5.89	NA	45.99	090
62163	.....	A	Neuroendoscopy w/fb removal	15.48	NA	9.95	4.00	NA	29.43	090
62164	.....	A	Remove brain tumor w/scope	27.46	NA	14.99	5.36	NA	47.81	090
62165	.....	A	Remove pituit tumor w/scope	21.97	NA	13.42	3.00	NA	38.39	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
62180	.....	A	Establish brain cavity shunt	21.03	NA	12.32	4.97	NA	38.32	090
62190	.....	A	Establish brain cavity shunt	11.05	NA	7.10	2.79	NA	20.94	090
62192	.....	A	Establish brain cavity shunt	12.23	NA	7.64	3.01	NA	22.88	090
62194	.....	A	Replace/irrigate catheter	5.02	NA	2.44	0.92	NA	8.38	010
62200	.....	A	Establish brain cavity shunt	18.29	NA	10.87	4.64	NA	33.80	090
62201	.....	A	Brain cavity shunt w/scope	14.84	NA	9.47	3.67	NA	27.98	090
62220	.....	A	Establish brain cavity shunt	12.98	NA	8.00	3.34	NA	24.32	090
62223	.....	A	Establish brain cavity shunt	12.85	NA	8.26	3.13	NA	24.24	090
62225	.....	A	Replace/irrigate catheter	5.40	NA	4.10	1.39	NA	10.89	090
62230	.....	A	Replace/revise brain shunt	10.52	NA	6.50	2.70	NA	19.72	090
62252	26	A	Csf shunt reprogram	0.74	0.37	0.37	0.19	1.30	1.30	XXX
62252	TC	A	Csf shunt reprogram	0.00	1.10	NA	0.02	1.12	NA	XXX
62252	.....	A	Csf shunt reprogram	0.74	1.47	NA	0.21	2.42	NA	XXX
62256	.....	A	Remove brain cavity shunt	6.59	NA	4.70	1.71	NA	13.00	090
62258	.....	A	Replace brain cavity shunt	14.52	NA	8.74	3.73	NA	26.99	090
62263	.....	A	Epidural lysis mult sessions	6.13	12.73	3.20	0.41	19.27	9.74	010
62264	.....	A	Epidural lysis on single day	4.42	7.75	1.42	0.27	12.44	6.11	010
62268	.....	A	Drain spinal cord cyst	4.73	11.56	2.15	0.43	16.72	7.31	000
62269	.....	A	Needle biopsy, spinal cord	5.01	14.72	1.98	0.37	20.10	7.36	000
62270	.....	A	Spinal fluid tap, diagnostic	1.13	3.00	0.56	0.08	4.21	1.77	000
62272	.....	A	Drain cerebro spinal fluid	1.35	3.62	0.71	0.18	5.15	2.24	000
62273	.....	A	Inject epidural patch	2.15	2.72	0.71	0.13	5.00	2.99	000
62280	.....	A	Treat spinal cord lesion	2.63	6.95	1.01	0.30	9.88	3.94	010
62281	.....	A	Treat spinal cord lesion	2.66	5.67	0.89	0.19	8.52	3.74	010
62282	.....	A	Treat spinal canal lesion	2.33	8.38	0.92	0.17	10.88	3.42	010
62284	.....	A	Injection for myelogram	1.54	4.97	0.68	0.13	6.64	2.35	000
62287	.....	A	Percutaneous diskectomy	8.07	NA	5.57	0.58	NA	14.22	090
62290	.....	A	Inject for spine disk x-ray	3.00	7.15	1.38	0.23	10.38	4.61	000
62291	.....	A	Inject for spine disk x-ray	2.91	5.95	1.23	0.26	9.12	4.40	000
62292	.....	A	Injection into disk lesion	7.85	NA	4.48	0.82	NA	13.15	090
62294	.....	A	Injection into spinal artery	11.81	NA	5.60	1.24	NA	18.65	090
62310	.....	A	Inject spine c/t	1.91	4.82	0.65	0.12	6.85	2.68	000
62311	.....	A	Inject spine l/s (cd)	1.54	4.93	0.59	0.09	6.56	2.22	000
62318	.....	A	Inject spine w/cath, c/t	2.04	5.74	0.65	0.12	7.90	2.81	000
62319	.....	A	Inject spine w/cath l/s (cd)	1.87	4.99	0.61	0.11	6.97	2.59	000
62350	.....	A	Implant spinal canal cath	6.86	NA	3.95	1.02	NA	11.83	090
62351	.....	A	Implant spinal canal cath	9.99	NA	7.14	2.24	NA	19.37	090
62355	.....	A	Remove spinal canal catheter	5.44	NA	3.17	0.71	NA	9.32	090
62360	.....	A	Insert spine infusion device	2.62	NA	2.69	0.34	NA	5.65	090
62361	.....	A	Implant spine infusion pump	5.41	NA	3.93	0.80	NA	10.14	090
62362	.....	A	Implant spine infusion pump	7.03	NA	4.37	1.18	NA	12.58	090
62365	.....	A	Remove spine infusion device	5.41	NA	3.59	0.86	NA	9.86	090
62367	.....	A	Analyze spine infusion pump	0.48	0.61	0.10	0.03	1.12	0.61	XXX
62368	.....	A	Analyze spine infusion pump	0.75	0.69	0.17	0.06	1.50	0.98	XXX
63001	.....	A	Removal of spinal lamina	15.80	NA	9.54	3.76	NA	29.10	090
63003	.....	A	Removal of spinal lamina	15.93	NA	9.89	3.72	NA	29.54	090
63005	.....	A	Removal of spinal lamina	14.90	NA	10.00	3.34	NA	28.24	090
63011	.....	A	Removal of spinal lamina	14.50	NA	8.29	3.37	NA	26.16	090
63012	.....	A	Removal of spinal lamina	15.38	NA	10.15	3.48	NA	29.01	090
63015	.....	A	Removal of spinal lamina	19.32	NA	11.90	4.75	NA	35.97	090
63016	.....	A	Removal of spinal lamina	19.17	NA	11.81	4.58	NA	35.56	090
63017	.....	A	Removal of spinal lamina	15.92	NA	10.42	3.63	NA	29.97	090
63020	.....	A	Neck spine disk surgery	14.79	NA	9.70	3.71	NA	28.20	090
63030	.....	A	Low back disk surgery	11.98	NA	8.44	3.00	NA	23.42	090
63035	.....	A	Spinal disk surgery add-on	3.15	NA	1.59	0.79	NA	5.53	ZZZ
63040	.....	A	Laminotomy, single cervical	18.78	NA	11.53	4.67	NA	34.98	090
63042	.....	A	Laminotomy, single lumbar	17.44	NA	11.37	4.25	NA	33.06	090
63043	.....	C	Laminotomy, add'l cervical	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
63044	.....	C	Laminotomy, add'l lumbar	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
63045	.....	A	Removal of spinal lamina	16.48	NA	10.38	3.98	NA	30.84	090
63046	.....	A	Removal of spinal lamina	15.78	NA	10.21	3.55	NA	29.54	090
63047	.....	A	Removal of spinal lamina	14.59	NA	9.92	3.23	NA	27.74	090
63048	.....	A	Remove spinal lamina add-on	3.26	NA	1.66	0.72	NA	5.64	ZZZ
63050	.....	A	Cervical laminoplasty	20.75	NA	11.87	4.66	NA	37.28	090
63051	.....	A	C-laminoplasty w/graft/plate	24.25	NA	13.51	4.66	NA	42.42	090
63055	.....	A	Decompress spinal cord	21.96	NA	13.17	5.27	NA	40.40	090
63056	.....	A	Decompress spinal cord	20.33	NA	12.60	4.75	NA	37.68	090
63057	.....	A	Decompress spine cord add-on	5.25	NA	2.64	1.22	NA	9.11	ZZZ
63064	.....	A	Decompress spinal cord	24.57	NA	14.46	5.69	NA	44.72	090
63066	.....	A	Decompress spine cord add-on	3.26	NA	1.66	0.69	NA	5.61	ZZZ
63075	.....	A	Neck spine disk surgery	19.38	NA	12.12	4.62	NA	36.12	090
63076	.....	A	Neck spine disk surgery	4.04	NA	2.06	0.96	NA	7.06	ZZZ
63077	.....	A	Spine disk surgery, thorax	21.41	NA	12.83	3.98	NA	38.22	090
63078	.....	A	Spine disk surgery, thorax	3.28	NA	1.64	0.66	NA	5.58	ZZZ
63081	.....	A	Removal of vertebral body	23.69	NA	14.36	5.54	NA	43.59	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
63082	.....	A	Remove vertebral body add-on	4.36	NA	2.23	1.02	NA	7.61	ZZZ
63085	.....	A	Removal of vertebral body	26.88	NA	15.51	4.48	NA	46.87	090
63086	.....	A	Remove vertebral body add-on	3.19	NA	1.59	0.59	NA	5.37	ZZZ
63087	.....	A	Removal of vertebral body	35.52	NA	19.51	6.20	NA	61.23	090
63088	.....	A	Remove vertebral body add-on	4.32	NA	2.18	0.82	NA	7.32	ZZZ
63090	.....	A	Removal of vertebral body	28.12	NA	16.08	4.21	NA	48.41	090
63091	.....	A	Remove vertebral body add-on	3.03	NA	1.46	0.48	NA	4.97	ZZZ
63101	.....	A	Removal of vertebral body	31.95	NA	19.33	5.69	NA	56.97	090
63102	.....	A	Removal of vertebral body	31.95	NA	19.33	5.69	NA	56.97	090
63103	.....	A	Remove vertebral body add-on	4.82	NA	2.51	0.69	NA	8.02	ZZZ
63170	.....	A	Incise spinal cord tract(s)	19.80	NA	11.89	4.86	NA	36.55	090
63172	.....	A	Drainage of spinal cyst	17.63	NA	10.67	4.48	NA	32.78	090
63173	.....	A	Drainage of spinal cyst	21.96	NA	12.84	5.68	NA	40.48	090
63180	.....	A	Revise spinal cord ligaments	18.24	NA	11.01	3.95	NA	33.20	090
63182	.....	A	Revise spinal cord ligaments	20.47	NA	10.98	5.30	NA	36.75	090
63185	.....	A	Incise spinal column/nerves	15.02	NA	8.11	2.79	NA	25.92	090
63190	.....	A	Incise spinal column/nerves	17.42	NA	10.16	3.24	NA	30.82	090
63191	.....	A	Incise spinal column/nerves	17.51	NA	10.50	6.34	NA	34.35	090
63194	.....	A	Incise spinal column & cord	19.16	NA	11.74	3.26	NA	34.16	090
63195	.....	A	Incise spinal column & cord	18.81	NA	11.07	4.87	NA	34.75	090
63196	.....	A	Incise spinal column & cord	22.27	NA	13.42	5.76	NA	41.45	090
63197	.....	A	Incise spinal column & cord	21.08	NA	12.24	5.36	NA	38.68	090
63198	.....	A	Incise spinal column & cord	25.34	NA	8.45	6.43	NA	40.22	090
63199	.....	A	Incise spinal column & cord	26.85	NA	15.07	1.40	NA	43.32	090
63200	.....	A	Release of spinal cord	19.15	NA	11.32	4.96	NA	35.43	090
63250	.....	A	Revise spinal cord vessels	40.70	NA	19.98	9.01	NA	69.69	090
63251	.....	A	Revise spinal cord vessels	41.14	NA	22.65	10.41	NA	74.20	090
63252	.....	A	Revise spinal cord vessels	41.13	NA	22.29	10.64	NA	74.06	090
63265	.....	A	Excise intraspinal lesion	21.53	NA	12.80	5.43	NA	39.76	090
63266	.....	A	Excise intraspinal lesion	22.27	NA	13.21	5.54	NA	41.02	090
63267	.....	A	Excise intraspinal lesion	17.92	NA	11.10	4.37	NA	33.39	090
63268	.....	A	Excise intraspinal lesion	18.49	NA	10.39	3.69	NA	32.57	090
63270	.....	A	Excise intraspinal lesion	26.76	NA	15.50	6.82	NA	49.08	090
63271	.....	A	Excise intraspinal lesion	26.88	NA	15.61	6.90	NA	49.39	090
63272	.....	A	Excise intraspinal lesion	25.28	NA	14.72	6.18	NA	46.18	090
63273	.....	A	Excise intraspinal lesion	24.25	NA	14.37	5.74	NA	44.36	090
63275	.....	A	Biopsy/excise spinal tumor	23.64	NA	13.80	5.80	NA	43.24	090
63276	.....	A	Biopsy/excise spinal tumor	23.41	NA	13.71	5.83	NA	42.95	090
63277	.....	A	Biopsy/excise spinal tumor	20.80	NA	12.55	5.01	NA	38.36	090
63278	.....	A	Biopsy/excise spinal tumor	20.53	NA	12.42	4.55	NA	37.50	090
63280	.....	A	Biopsy/excise spinal tumor	28.31	NA	16.35	7.27	NA	51.93	090
63281	.....	A	Biopsy/excise spinal tumor	28.01	NA	16.21	7.17	NA	51.39	090
63282	.....	A	Biopsy/excise spinal tumor	26.35	NA	15.36	6.76	NA	48.47	090
63283	.....	A	Biopsy/excise spinal tumor	24.96	NA	14.69	6.26	NA	45.91	090
63285	.....	A	Biopsy/excise spinal tumor	35.95	NA	19.99	9.18	NA	65.12	090
63286	.....	A	Biopsy/excise spinal tumor	35.58	NA	19.95	9.21	NA	64.74	090
63287	.....	A	Biopsy/excise spinal tumor	36.64	NA	20.47	9.39	NA	66.50	090
63290	.....	A	Biopsy/excise spinal tumor	37.32	NA	20.64	9.02	NA	66.98	090
63295	.....	A	Repair of laminectomy defect	5.25	NA	2.15	1.03	NA	8.43	ZZZ
63300	.....	A	Removal of vertebral body	24.39	NA	14.33	5.97	NA	44.69	090
63301	.....	A	Removal of vertebral body	27.56	NA	15.59	5.39	NA	48.54	090
63302	.....	A	Removal of vertebral body	27.77	NA	15.89	5.53	NA	49.19	090
63303	.....	A	Removal of vertebral body	30.45	NA	16.95	4.68	NA	52.08	090
63304	.....	A	Removal of vertebral body	30.28	NA	17.31	6.41	NA	54.00	090
63305	.....	A	Removal of vertebral body	31.98	NA	18.09	5.71	NA	55.78	090
63306	.....	A	Removal of vertebral body	32.17	NA	17.84	8.33	NA	58.34	090
63307	.....	A	Removal of vertebral body	31.58	NA	16.85	4.46	NA	52.89	090
63308	.....	A	Remove vertebral body add-on	5.24	NA	2.61	1.29	NA	9.14	ZZZ
63600	.....	A	Remove spinal cord lesion	14.00	NA	5.41	1.52	NA	20.93	090
63610	.....	A	Stimulation of spinal cord	8.72	59.85	2.26	0.86	69.43	11.84	000
63615	.....	A	Remove lesion of spinal cord	16.26	NA	9.29	2.84	NA	28.39	090
63650	.....	A	Implant neuroelectrodes	6.73	NA	3.18	0.53	NA	10.44	090
63655	.....	A	Implant neuroelectrodes	10.27	NA	6.91	2.43	NA	19.61	090
63660	.....	A	Revise/remove neuroelectrode	6.15	NA	3.62	0.78	NA	10.55	090
63685	.....	A	Insrt/redo spine n generator	7.03	NA	4.15	1.05	NA	12.23	090
63688	.....	A	Revise/remove neuroreceiver	5.38	NA	3.56	0.89	NA	9.83	090
63700	.....	A	Repair of spinal herniation	16.51	NA	10.33	3.52	NA	30.36	090
63702	.....	A	Repair of spinal herniation	18.45	NA	11.06	4.12	NA	33.63	090
63704	.....	A	Repair of spinal herniation	21.15	NA	12.95	4.57	NA	38.67	090
63706	.....	A	Repair of spinal herniation	24.07	NA	13.61	6.23	NA	43.91	090
63707	.....	A	Repair spinal fluid leakage	11.24	NA	7.72	2.51	NA	21.47	090
63709	.....	A	Repair spinal fluid leakage	14.30	NA	9.42	3.09	NA	26.81	090
63710	.....	A	Graft repair of spine defect	14.05	NA	9.06	3.40	NA	26.51	090
63740	.....	A	Install spinal shunt	11.34	NA	7.36	2.93	NA	21.63	090
63741	.....	A	Install spinal shunt	8.24	NA	4.76	1.66	NA	14.66	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
63744	.....	A	Revision of spinal shunt	8.09	NA	5.27	1.89	NA	15.25	090
63746	.....	A	Removal of spinal shunt	6.42	NA	3.78	1.53	NA	11.73	090
64400	.....	A	N block inj, trigeminal	1.11	1.90	0.43	0.07	3.08	1.61	000
64402	.....	A	N block inj, facial	1.25	1.61	0.60	0.09	2.95	1.94	000
64405	.....	A	N block inj, occipital	1.32	1.46	0.46	0.08	2.86	1.86	000
64408	.....	A	N block inj, vagus	1.41	1.58	0.85	0.10	3.09	2.36	000
64410	.....	A	N block inj, phrenic	1.43	2.51	0.46	0.09	4.03	1.98	000
64412	.....	A	N block inj, spinal accessor	1.18	2.66	0.43	0.08	3.92	1.69	000
64413	.....	A	N block inj, cervical plexus	1.40	1.85	0.50	0.08	3.33	1.98	000
64415	.....	A	N block inj, brachial plexus	1.48	2.81	0.46	0.09	4.38	2.03	000
64416	.....	A	N block cont infuse, b plex	3.49	NA	0.79	0.31	NA	4.59	010
64417	.....	A	N block inj, axillary	1.44	3.04	0.49	0.11	4.59	2.04	000
64418	.....	A	N block inj, suprascapular	1.32	2.63	0.44	0.07	4.02	1.83	000
64420	.....	A	N block inj, intercost, sng	1.18	3.89	0.42	0.08	5.15	1.68	000
64421	.....	A	N block inj, intercost, mlt	1.68	6.10	0.52	0.11	7.89	2.31	000
64425	.....	A	N block inj, ilio-ing/hypogi	1.75	1.65	0.54	0.13	3.53	2.42	000
64430	.....	A	N block inj, pudendal	1.46	2.52	0.55	0.10	4.08	2.11	000
64435	.....	A	N block inj, paracervical	1.45	2.53	0.69	0.16	4.14	2.30	000
64445	.....	A	N block inj, sciatic, sng	1.48	2.68	0.50	0.10	4.26	2.08	000
64446	.....	A	N blk inj, sciatic, cont inf	3.25	NA	1.00	0.20	NA	4.45	010
64447	.....	A	N block inj fem, single	1.50	NA	0.43	0.09	NA	2.02	000
64448	.....	A	N block inj fem, cont inf	3.00	NA	0.81	0.18	NA	3.99	010
64449	.....	A	N block inj, lumbar plexus	3.00	NA	0.96	0.15	NA	4.11	010
64450	.....	A	N block, other peripheral	1.27	1.24	0.48	0.13	2.64	1.88	000
64470	.....	A	Inj paravertebral c/t	1.85	7.25	0.71	0.11	9.21	2.67	000
64472	.....	A	Inj paravertebral c/t add-on	1.29	2.34	0.34	0.08	3.71	1.71	ZZZ
64475	.....	A	Inj paravertebral l/s	1.41	6.90	0.63	0.10	8.41	2.14	000
64476	.....	A	Inj paravertebral l/s add-on	0.98	2.13	0.24	0.07	3.18	1.29	ZZZ
64479	.....	A	Inj foramen epidural c/t	2.20	7.51	0.89	0.12	9.83	3.21	000
64480	.....	A	Inj foramen epidural add-on	1.54	2.85	0.47	0.10	4.49	2.11	ZZZ
64483	.....	A	Inj foramen epidural l/s	1.90	7.91	0.83	0.11	9.92	2.84	000
64484	.....	A	Inj foramen epidural add-on	1.33	3.29	0.37	0.08	4.70	1.78	ZZZ
64505	.....	A	N block, spenopalatine gangl	1.36	1.24	0.66	0.10	2.70	2.12	000
64508	.....	A	N block, carotid sinus s/p	1.12	3.33	0.74	0.07	4.52	1.93	000
64510	.....	A	N block, stellate ganglion	1.22	3.46	0.51	0.07	4.75	1.80	000
64517	.....	A	N block inj, hypogas plxs	2.20	2.73	0.87	0.11	5.04	3.18	000
64520	.....	A	N block, lumbar/thoracic	1.35	5.15	0.55	0.08	6.58	1.98	000
64530	.....	A	N block inj, celiac pelus	1.58	4.46	0.65	0.10	6.14	2.33	000
64550	.....	A	Apply neurostimulator	0.18	0.28	0.05	0.01	0.47	0.24	000
64553	.....	A	Implant neuroelectrodes	2.31	2.84	1.86	0.18	5.33	4.35	010
64555	.....	A	Implant neuroelectrodes	2.27	3.11	1.19	0.19	5.57	3.65	010
64560	.....	A	Implant neuroelectrodes	2.36	2.64	1.28	0.22	5.22	3.86	010
64561	.....	A	Implant neuroelectrodes	6.73	30.14	2.78	0.51	37.38	10.02	010
64565	.....	A	Implant neuroelectrodes	1.76	3.29	1.26	0.13	5.18	3.15	010
64573	.....	A	Implant neuroelectrodes	7.49	NA	5.26	1.60	NA	14.35	090
64575	.....	A	Implant neuroelectrodes	4.34	NA	2.68	0.61	NA	7.63	090
64577	.....	A	Implant neuroelectrodes	4.61	NA	3.29	1.04	NA	8.94	090
64580	.....	A	Implant neuroelectrodes	4.11	NA	3.56	0.36	NA	8.03	090
64581	.....	A	Implant neuroelectrodes	13.48	NA	5.39	1.05	NA	19.92	090
64585	.....	A	Revise/remove neuroelectrode	2.06	11.31	2.14	0.20	13.57	4.40	010
64590	.....	A	Insrt/redo perph n generator	2.40	7.16	2.29	0.19	9.75	4.88	010
64595	.....	A	Revise/remove neuroreceiver	1.73	10.42	1.93	0.19	12.34	3.85	010
64600	.....	A	Injection treatment of nerve	3.44	9.38	1.65	0.34	13.16	5.43	010
64605	.....	A	Injection treatment of nerve	5.60	9.58	2.19	0.79	15.97	8.58	010
64610	.....	A	Injection treatment of nerve	7.15	8.89	3.72	1.58	17.62	12.45	010
64612	.....	A	Destroy nerve, face muscle	1.96	2.49	1.32	0.11	4.56	3.39	010
64613	.....	A	Destroy nerve, neck muscle	1.96	2.94	1.22	0.11	5.01	3.29	010
64614	.....	A	Destroy nerve, extrem musc	2.20	3.23	1.31	0.10	5.53	3.61	010
64620	.....	A	Injection treatment of nerve	2.84	5.07	1.33	0.20	8.11	4.37	010
64622	.....	A	Destr paravertebrl nerve l/s	3.00	7.78	1.37	0.18	10.96	4.55	010
64623	.....	A	Destr paravertebral n add-on	0.99	2.97	0.22	0.06	4.02	1.27	ZZZ
64626	.....	A	Destr paravertebrl nerve c/t	3.28	7.80	1.97	0.20	11.28	5.45	010
64627	.....	A	Destr paravertebral n add-on	1.16	4.54	0.27	0.07	5.77	1.50	ZZZ
64630	.....	A	Injection treatment of nerve	3.00	2.74	1.41	0.22	5.96	4.63	010
64640	.....	A	Injection treatment of nerve	2.76	4.19	1.85	0.29	7.24	4.90	010
64650	.....	A	Chemodenerv eccrine glands	0.70	0.87	0.30	0.06	1.63	1.06	000
64653	.....	A	Chemodenerv eccrine glands	0.88	0.92	0.38	0.08	1.88	1.34	000
64680	.....	A	Injection treatment of nerve	2.62	6.73	1.43	0.18	9.53	4.23	010
64681	.....	A	Injection treatment of nerve	3.54	9.32	2.07	0.28	13.14	5.89	010
64702	.....	A	Revise finger/toe nerve	4.22	NA	3.87	0.61	NA	8.70	090
64704	.....	A	Revise hand/foot nerve	4.56	NA	3.32	0.61	NA	8.49	090
64708	.....	A	Revise arm/leg nerve	6.11	NA	4.87	0.96	NA	11.94	090
64712	.....	A	Revision of sciatic nerve	7.74	NA	4.97	0.95	NA	13.66	090
64713	.....	A	Revision of arm nerve(s)	10.98	NA	5.89	1.82	NA	18.69	090
64714	.....	A	Revise low back nerve(s)	10.31	NA	4.21	1.19	NA	15.71	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
64716	.....	A	Revision of cranial nerve	6.30	NA	5.99	0.63	NA	12.92	090
64718	.....	A	Revise ulnar nerve at elbow	5.98	NA	6.01	1.05	NA	13.04	090
64719	.....	A	Revise ulnar nerve at wrist	4.84	NA	4.53	0.77	NA	10.14	090
64721	.....	A	Carpal tunnel surgery	4.28	NA	5.38	0.73	NA	10.39	090
64722	.....	A	Relieve pressure on nerve(s)	4.69	NA	3.05	0.48	NA	8.22	090
64726	.....	A	Release foot/toe nerve	4.17	NA	2.80	0.54	NA	7.51	090
64727	.....	A	Internal nerve revision	3.10	NA	1.50	0.48	NA	5.08	ZZZ
64732	.....	A	Incision of brow nerve	4.40	NA	3.51	0.98	NA	8.89	090
64734	.....	A	Incision of cheek nerve	4.91	NA	4.06	0.89	NA	9.86	090
64736	.....	A	Incision of chin nerve	4.59	NA	4.03	0.52	NA	9.14	090
64738	.....	A	Incision of jaw nerve	5.72	NA	4.62	1.08	NA	11.42	090
64740	.....	A	Incision of tongue nerve	5.58	NA	5.13	0.69	NA	11.40	090
64742	.....	A	Incision of facial nerve	6.21	NA	4.71	0.73	NA	11.65	090
64744	.....	A	Incise nerve, back of head	5.23	NA	3.78	1.16	NA	10.17	090
64746	.....	A	Incise diaphragm nerve	5.92	NA	4.51	0.82	NA	11.25	090
64752	.....	A	Incision of vagus nerve	7.05	NA	4.29	0.93	NA	12.27	090
64755	.....	A	Incision of stomach nerves	13.50	NA	5.65	1.83	NA	20.98	090
64760	.....	A	Incision of vagus nerve	6.95	NA	3.46	0.81	NA	11.22	090
64761	.....	A	Incision of pelvis nerve	6.40	NA	3.53	0.53	NA	10.46	090
64763	.....	A	Incise hip/thigh nerve	6.92	NA	5.21	0.94	NA	13.07	090
64766	.....	A	Incise hip/thigh nerve	8.66	NA	5.26	1.06	NA	14.98	090
64771	.....	A	Sever cranial nerve	7.34	NA	5.57	1.23	NA	14.14	090
64772	.....	A	Incision of spinal nerve	7.20	NA	4.93	1.40	NA	13.53	090
64774	.....	A	Remove skin nerve lesion	5.16	NA	3.84	0.74	NA	9.74	090
64776	.....	A	Remove digit nerve lesion	5.11	NA	3.69	0.76	NA	9.56	090
64778	.....	A	Digit nerve surgery add-on	3.11	NA	1.50	0.46	NA	5.07	ZZZ
64782	.....	A	Remove limb nerve lesion	6.22	NA	3.78	0.86	NA	10.86	090
64783	.....	A	Limb nerve surgery add-on	3.71	NA	1.84	0.51	NA	6.06	ZZZ
64784	.....	A	Remove nerve lesion	9.81	NA	6.61	1.38	NA	17.80	090
64786	.....	A	Remove sciatic nerve lesion	15.44	NA	9.86	2.60	NA	27.90	090
64787	.....	A	Implant nerve end	4.29	NA	2.13	0.58	NA	7.00	ZZZ
64788	.....	A	Remove skin nerve lesion	4.60	NA	3.47	0.73	NA	8.80	090
64790	.....	A	Removal of nerve lesion	11.29	NA	7.22	2.10	NA	20.61	090
64792	.....	A	Removal of nerve lesion	14.90	NA	8.85	2.48	NA	26.23	090
64795	.....	A	Biopsy of nerve	3.01	NA	1.56	0.52	NA	5.09	000
64802	.....	A	Remove sympathetic nerves	9.14	NA	5.14	1.29	NA	15.57	090
64804	.....	A	Remove sympathetic nerves	14.62	NA	7.18	2.14	NA	23.94	090
64809	.....	A	Remove sympathetic nerves	13.65	NA	5.78	1.50	NA	20.93	090
64818	.....	A	Remove sympathetic nerves	10.28	NA	5.30	1.33	NA	16.91	090
64820	.....	A	Remove sympathetic nerves	10.35	NA	7.14	1.49	NA	18.98	090
64821	.....	A	Remove sympathetic nerves	8.74	NA	7.36	1.24	NA	17.34	090
64822	.....	A	Remove sympathetic nerves	8.74	NA	7.25	1.30	NA	17.29	090
64823	.....	A	Remove sympathetic nerves	10.35	NA	8.15	1.57	NA	20.07	090
64831	.....	A	Repair of digit nerve	9.43	NA	7.09	1.41	NA	17.93	090
64832	.....	A	Repair nerve add-on	5.65	NA	2.94	0.85	NA	9.44	ZZZ
64834	.....	A	Repair of hand or foot nerve	10.17	NA	7.11	1.54	NA	18.82	090
64835	.....	A	Repair of hand or foot nerve	10.92	NA	7.71	1.73	NA	20.36	090
64836	.....	A	Repair of hand or foot nerve	10.92	NA	7.68	1.67	NA	20.27	090
64837	.....	A	Repair nerve add-on	6.25	NA	3.24	0.97	NA	10.46	ZZZ
64840	.....	A	Repair of leg nerve	13.00	NA	8.27	1.37	NA	22.64	090
64856	.....	A	Repair/transpose nerve	13.78	NA	9.21	2.12	NA	25.11	090
64857	.....	A	Repair arm/leg nerve	14.47	NA	9.66	2.21	NA	26.34	090
64858	.....	A	Repair sciatic nerve	16.47	NA	10.80	3.33	NA	30.60	090
64859	.....	A	Nerve surgery	4.25	NA	2.20	0.67	NA	7.12	ZZZ
64861	.....	A	Repair of arm nerves	19.21	NA	11.80	4.08	NA	35.09	090
64862	.....	A	Repair of low back nerves	19.41	NA	11.96	4.31	NA	35.68	090
64864	.....	A	Repair of facial nerve	12.53	NA	8.79	1.26	NA	22.58	090
64865	.....	A	Repair of facial nerve	15.22	NA	13.56	1.50	NA	30.28	090
64866	.....	A	Fusion of facial/other nerve	15.72	NA	13.20	2.04	NA	30.96	090
64868	.....	A	Fusion of facial/other nerve	14.02	NA	11.46	1.43	NA	26.91	090
64870	.....	A	Fusion of facial/other nerve	15.97	NA	8.75	1.30	NA	26.02	090
64872	.....	A	Subsequent repair of nerve	1.99	NA	1.08	0.29	NA	3.36	ZZZ
64874	.....	A	Repair & revise nerve add-on	2.98	NA	1.53	0.42	NA	4.93	ZZZ
64876	.....	A	Repair nerve/shorten bone	3.37	NA	1.75	0.47	NA	5.59	ZZZ
64885	.....	A	Nerve graft, head or neck	17.50	NA	11.63	1.63	NA	30.76	090
64886	.....	A	Nerve graft, head or neck	20.72	NA	13.58	2.08	NA	36.38	090
64890	.....	A	Nerve graft, hand or foot	15.13	NA	10.02	2.29	NA	27.44	090
64891	.....	A	Nerve graft, hand or foot	16.12	NA	7.60	1.63	NA	25.35	090
64892	.....	A	Nerve graft, arm or leg	14.63	NA	8.89	2.47	NA	25.99	090
64893	.....	A	Nerve graft, arm or leg	15.58	NA	9.89	2.61	NA	28.08	090
64895	.....	A	Nerve graft, hand or foot	19.22	NA	9.68	2.57	NA	31.47	090
64896	.....	A	Nerve graft, hand or foot	20.46	NA	11.01	3.16	NA	34.63	090
64897	.....	A	Nerve graft, arm or leg	18.21	NA	10.72	2.54	NA	31.47	090
64898	.....	A	Nerve graft, arm or leg	19.47	NA	11.82	2.77	NA	34.06	090
64901	.....	A	Nerve graft add-on	10.20	NA	5.28	1.37	NA	16.85	ZZZ

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
64902	.....	A	Nerve graft add-on	11.81	NA	5.98	1.55	NA	19.34	ZZZ
64905	.....	A	Nerve pedicle transfer	14.00	NA	8.51	2.00	NA	24.51	090
64907	.....	A	Nerve pedicle transfer	18.80	NA	12.56	3.16	NA	34.52	090
64999	.....	C	Nervous system surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
65091	.....	A	Revise eye	6.45	NA	8.37	0.32	NA	15.14	090
65093	.....	A	Revise eye with implant	6.86	NA	8.74	0.34	NA	15.94	090
65101	.....	A	Removal of eye	7.02	NA	9.55	0.35	NA	16.92	090
65103	.....	A	Remove eye/insert implant	7.56	NA	9.76	0.37	NA	17.69	090
65105	.....	A	Remove eye/attach implant	8.48	NA	10.49	0.42	NA	19.39	090
65110	.....	A	Removal of eye	13.93	NA	13.71	0.81	NA	28.45	090
65112	.....	A	Remove eye/revise socket	16.36	NA	16.18	1.30	NA	33.84	090
65114	.....	A	Remove eye/revise socket	17.50	NA	16.39	1.02	NA	34.91	090
65125	.....	A	Revise ocular implant	3.12	8.83	3.61	0.19	12.14	6.92	090
65130	.....	A	Insert ocular implant	7.14	NA	9.19	0.35	NA	16.68	090
65135	.....	A	Insert ocular implant	7.32	NA	9.34	0.36	NA	17.02	090
65140	.....	A	Attach ocular implant	8.01	NA	9.90	0.40	NA	18.31	090
65150	.....	A	Revise ocular implant	6.25	NA	7.99	0.31	NA	14.55	090
65155	.....	A	Reinsert ocular implant	8.65	NA	10.51	0.50	NA	19.66	090
65175	.....	A	Removal of ocular implant	6.27	NA	8.50	0.31	NA	15.08	090
65205	.....	A	Remove foreign body from eye	0.71	0.64	0.29	0.03	1.38	1.03	000
65210	.....	A	Remove foreign body from eye	0.84	0.81	0.38	0.04	1.69	1.26	000
65220	.....	A	Remove foreign body from eye	0.71	0.64	0.28	0.05	1.40	1.04	000
65222	.....	A	Remove foreign body from eye	0.93	0.89	0.38	0.04	1.86	1.35	000
65235	.....	A	Remove foreign body from eye	7.56	NA	6.76	0.37	NA	14.69	090
65260	.....	A	Remove foreign body from eye	10.94	NA	9.68	0.57	NA	21.19	090
65265	.....	A	Remove foreign body from eye	12.57	NA	10.65	0.62	NA	23.84	090
65270	.....	A	Repair of eye wound	1.90	5.24	1.39	0.09	7.23	3.38	010
65272	.....	A	Repair of eye wound	3.81	7.73	3.30	0.19	11.73	7.30	090
65273	.....	A	Repair of eye wound	4.35	NA	3.59	0.22	NA	8.16	090
65275	.....	A	Repair of eye wound	5.33	6.33	3.95	0.26	11.92	9.54	090
65280	.....	A	Repair of eye wound	7.65	NA	6.25	0.38	NA	14.28	090
65285	.....	A	Repair of eye wound	12.88	NA	9.24	0.64	NA	22.76	090
65286	.....	A	Repair of eye wound	5.50	11.17	4.63	0.27	16.94	10.40	090
65290	.....	A	Repair of eye socket wound	5.40	NA	4.75	0.31	NA	10.46	090
65400	.....	A	Removal of eye lesion	6.05	8.35	6.14	0.30	14.70	12.49	090
65410	.....	A	Biopsy of cornea	1.47	2.12	0.97	0.07	3.66	2.51	000
65420	.....	A	Removal of eye lesion	4.16	8.88	4.45	0.21	13.25	8.82	090
65426	.....	A	Removal of eye lesion	5.24	10.20	4.93	0.25	15.69	10.42	090
65430	.....	A	Corneal smear	1.47	1.29	0.98	0.07	2.83	2.52	000
65435	.....	A	Curette/treat cornea	0.92	1.00	0.71	0.04	1.96	1.67	000
65436	.....	A	Curette/treat cornea	4.18	4.10	3.68	0.21	8.49	8.07	090
65450	.....	A	Treatment of corneal lesion	3.27	4.08	3.95	0.16	7.51	7.38	090
65600	.....	A	Revision of cornea	3.39	5.02	3.36	0.17	8.58	6.92	090
65710	.....	A	Corneal transplant	12.33	NA	11.23	0.61	NA	24.17	090
65730	.....	A	Corneal transplant	14.23	NA	12.05	0.70	NA	26.98	090
65750	.....	A	Corneal transplant	14.98	NA	12.00	0.74	NA	27.72	090
65755	.....	A	Corneal transplant	14.87	NA	11.92	0.73	NA	27.52	090
65760	.....	N	Revision of cornea	0.00	0.00	0.00	0.00	0.00	0.00	XXX
65765	.....	N	Revision of cornea	0.00	0.00	0.00	0.00	0.00	0.00	XXX
65767	.....	N	Corneal tissue transplant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
65770	.....	A	Revise cornea with implant	17.53	NA	13.24	0.87	NA	31.64	090
65771	.....	N	Radial keratotomy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
65772	.....	A	Correction of astigmatism	4.28	5.55	4.14	0.21	10.04	8.63	090
65775	.....	A	Correction of astigmatism	5.78	NA	5.97	0.28	NA	12.03	090
65780	.....	A	Ocular reconst, transplant	10.23	NA	10.32	0.44	NA	20.99	090
65781	.....	A	Ocular reconst, transplant	17.64	NA	13.71	0.44	NA	31.79	090
65782	.....	A	Ocular reconst, transplant	14.98	NA	12.02	0.44	NA	27.44	090
65800	.....	A	Drainage of eye	1.91	1.80	1.18	0.09	3.80	3.18	000
65805	.....	A	Drainage of eye	1.91	2.18	1.19	0.09	4.18	3.19	000
65810	.....	A	Drainage of eye	4.86	NA	4.71	0.24	NA	9.81	090
65815	.....	A	Drainage of eye	5.04	10.03	4.82	0.25	15.32	10.11	090
65820	.....	A	Relieve inner eye pressure	8.12	NA	9.08	0.40	NA	17.60	090
65850	.....	A	Incision of eye	10.50	NA	8.46	0.52	NA	19.48	090
65855	.....	A	Laser surgery of eye	3.84	4.32	3.11	0.19	8.35	7.14	010
65860	.....	A	Incise inner eye adhesions	3.54	4.05	2.51	0.18	7.77	6.23	090
65865	.....	A	Incise inner eye adhesions	5.59	NA	5.64	0.28	NA	11.51	090
65870	.....	A	Incise inner eye adhesions	6.26	NA	6.43	0.31	NA	13.00	090
65875	.....	A	Incise inner eye adhesions	6.53	NA	6.81	0.32	NA	13.66	090
65880	.....	A	Incise inner eye adhesions	7.08	NA	7.05	0.35	NA	14.48	090
65900	.....	A	Remove eye lesion	10.91	NA	10.28	0.54	NA	21.73	090
65920	.....	A	Remove implant of eye	8.39	NA	8.19	0.41	NA	16.99	090
65930	.....	A	Remove blood clot from eye	7.43	NA	6.85	0.37	NA	14.65	090
66020	.....	A	Injection treatment of eye	1.59	3.13	1.44	0.08	4.80	3.11	010
66030	.....	A	Injection treatment of eye	1.25	2.97	1.28	0.06	4.28	2.59	010
66130	.....	A	Remove eye lesion	7.68	9.65	5.63	0.38	17.71	13.69	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
66150	.....	A	Glaucoma surgery	8.29	NA	9.43	0.46	NA	18.18	090
66155	.....	A	Glaucoma surgery	8.28	NA	9.38	0.41	NA	18.07	090
66160	.....	A	Glaucoma surgery	10.15	NA	10.22	0.50	NA	20.87	090
66165	.....	A	Glaucoma surgery	8.00	NA	9.27	0.40	NA	17.67	090
66170	.....	A	Glaucoma surgery	12.14	NA	12.26	0.60	NA	25.00	090
66172	.....	A	Incision of eye	15.02	NA	15.24	0.74	NA	31.00	090
66180	.....	A	Implant eye shunt	14.53	NA	10.79	0.71	NA	26.03	090
66185	.....	A	Revise eye shunt	8.13	NA	7.40	0.40	NA	15.93	090
66220	.....	A	Repair eye lesion	7.76	NA	7.12	0.40	NA	15.28	090
66225	.....	A	Repair/graft eye lesion	11.03	NA	8.76	0.55	NA	20.34	090
66250	.....	A	Follow-up surgery of eye	5.97	11.72	5.50	0.30	17.99	11.77	090
66500	.....	A	Incision of iris	3.70	NA	4.65	0.18	NA	8.53	090
66505	.....	A	Incision of iris	4.07	NA	5.00	0.20	NA	9.27	090
66600	.....	A	Remove iris and lesion	8.67	NA	8.24	0.43	NA	17.34	090
66605	.....	A	Removal of iris	12.77	NA	10.05	0.77	NA	23.59	090
66625	.....	A	Removal of iris	5.12	NA	4.74	0.26	NA	10.12	090
66630	.....	A	Removal of iris	6.15	NA	5.73	0.31	NA	12.19	090
66635	.....	A	Removal of iris	6.24	NA	5.76	0.31	NA	12.31	090
66680	.....	A	Repair iris & ciliary body	5.43	NA	5.29	0.27	NA	10.99	090
66682	.....	A	Repair iris & ciliary body	6.20	NA	6.63	0.31	NA	13.14	090
66700	.....	A	Destruction, ciliary body	4.77	5.26	3.94	0.24	10.27	8.95	090
66710	.....	A	Ciliary transscleral therapy	4.77	5.18	3.85	0.23	10.18	8.85	090
66711	.....	A	Ciliary endoscopic ablation	6.60	NA	6.49	0.30	NA	13.39	090
66720	.....	A	Destruction, ciliary body	4.77	5.81	4.73	0.26	10.84	9.76	090
66740	.....	A	Destruction, ciliary body	4.77	5.10	3.98	0.23	10.10	8.98	090
66761	.....	A	Revision of iris	4.06	5.61	4.32	0.20	9.87	8.58	090
66762	.....	A	Revision of iris	4.57	5.67	4.30	0.23	10.47	9.10	090
66770	.....	A	Removal of inner eye lesion	5.17	6.10	4.81	0.26	11.53	10.24	090
66820	.....	A	Incision, secondary cataract	3.88	NA	5.83	0.19	NA	9.90	090
66821	.....	A	After cataract laser surgery	2.35	4.10	3.63	0.11	6.56	6.09	090
66825	.....	A	Reposition intraocular lens	8.22	NA	9.09	0.40	NA	17.71	090
66830	.....	A	Removal of lens lesion	8.19	NA	6.97	0.36	NA	15.52	090
66840	.....	A	Removal of lens material	7.90	NA	6.88	0.39	NA	15.17	090
66850	.....	A	Removal of lens material	9.10	NA	7.66	0.45	NA	17.21	090
66852	.....	A	Removal of lens material	9.96	NA	8.12	0.49	NA	18.57	090
66920	.....	A	Extraction of lens	8.85	NA	7.32	0.44	NA	16.61	090
66930	.....	A	Extraction of lens	10.16	NA	8.16	0.49	NA	18.81	090
66940	.....	A	Extraction of lens	8.92	NA	7.62	0.43	NA	16.97	090
66982	.....	A	Cataract surgery, complex	13.48	NA	9.89	0.63	NA	24.00	090
66983	.....	A	Cataract surg w/iol, 1 stage	8.98	NA	6.13	0.14	NA	15.25	090
66984	.....	A	Cataract surg w/iol, 1 stage	10.21	NA	7.44	0.39	NA	18.04	090
66985	.....	A	Insert lens prosthesis	8.38	NA	7.47	0.36	NA	16.21	090
66986	.....	A	Exchange lens prosthesis	12.26	NA	9.20	0.60	NA	22.06	090
66990	.....	A	Ophthalmic endoscope add-on	1.51	NA	0.69	0.07	NA	2.27	ZZZ
66999	.....	C	Eye surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
67005	.....	A	Partial removal of eye fluid	5.69	NA	4.87	0.28	NA	10.84	090
67010	.....	A	Partial removal of eye fluid	6.86	NA	5.43	0.34	NA	12.63	090
67015	.....	A	Release of eye fluid	6.91	NA	6.47	0.34	NA	13.72	090
67025	.....	A	Replace eye fluid	6.83	9.25	6.24	0.34	16.42	13.41	090
67027	.....	A	Implant eye drug system	10.83	NA	8.02	0.54	NA	19.39	090
67028	.....	A	Injection eye drug	2.52	2.71	1.46	0.12	5.35	4.10	000
67030	.....	A	Incise inner eye strands	4.83	NA	5.87	0.24	NA	10.94	090
67031	.....	A	Laser surgery, eye strands	3.66	4.61	3.65	0.18	8.45	7.49	090
67036	.....	A	Removal of inner eye fluid	11.87	NA	9.15	0.58	NA	21.60	090
67038	.....	A	Strip retinal membrane	21.21	NA	15.53	1.04	NA	37.78	090
67039	.....	A	Laser treatment of retina	14.50	NA	12.22	0.71	NA	27.43	090
67040	.....	A	Laser treatment of retina	17.20	NA	13.72	0.85	NA	31.77	090
67101	.....	A	Repair detached retina	7.52	9.15	6.55	0.37	17.04	14.44	090
67105	.....	A	Repair detached retina	7.40	8.10	6.17	0.37	15.87	13.94	090
67107	.....	A	Repair detached retina	14.82	NA	11.33	0.73	NA	26.88	090
67108	.....	A	Repair detached retina	20.79	NA	14.46	1.02	NA	36.27	090
67110	.....	A	Repair detached retina	8.80	10.26	7.41	0.44	19.50	16.65	090
67112	.....	A	Rerepair detached retina	16.83	NA	11.84	0.83	NA	29.50	090
67115	.....	A	Release encircling material	4.98	NA	5.09	0.25	NA	10.32	090
67120	.....	A	Remove eye implant material	5.97	8.60	5.55	0.29	14.86	11.81	090
67121	.....	A	Remove eye implant material	10.65	NA	8.55	0.53	NA	19.73	090
67141	.....	A	Treatment of retina	5.19	5.87	4.87	0.26	11.32	10.32	090
67145	.....	A	Treatment of retina	5.36	5.74	4.94	0.27	11.37	10.57	090
67208	.....	A	Treatment of retinal lesion	6.69	6.14	5.53	0.33	13.16	12.55	090
67210	.....	A	Treatment of retinal lesion	8.81	6.59	5.90	0.44	15.84	15.15	090
67218	.....	A	Treatment of retinal lesion	18.50	NA	12.19	0.92	NA	31.61	090
67220	.....	A	Treatment of choroid lesion	13.11	10.45	9.04	0.65	24.21	22.80	090
67221	.....	R	Ocular photodynamic ther	4.00	4.34	1.81	0.20	8.54	6.01	000
67225	.....	A	Eye photodynamic ther add-on	0.47	0.25	0.21	0.02	0.74	0.70	ZZZ
67227	.....	A	Treatment of retinal lesion	6.57	6.60	5.54	0.33	13.50	12.44	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
67228	.....	A	Treatment of retinal lesion	12.72	11.51	8.56	0.63	24.86	21.91	090
67250	.....	A	Reinforce eye wall	8.65	NA	9.20	0.47	NA	18.32	090
67255	.....	A	Reinforce/graft eye wall	8.89	NA	9.92	0.44	NA	19.25	090
67299	.....	C	Eye surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
67311	.....	A	Revise eye muscle	6.64	NA	6.04	0.37	NA	13.05	090
67312	.....	A	Revise two eye muscles	8.53	NA	6.77	0.43	NA	15.73	090
67314	.....	A	Revise eye muscle	7.51	NA	6.57	0.39	NA	14.47	090
67316	.....	A	Revise two eye muscles	9.65	NA	7.52	0.49	NA	17.66	090
67318	.....	A	Revise eye muscle(s)	7.84	NA	6.95	0.41	NA	15.20	090
67320	.....	A	Revise eye muscle(s) add-on	4.32	NA	1.96	0.22	NA	6.50	ZZZ
67331	.....	A	Eye surgery follow-up add-on	4.05	NA	1.84	0.21	NA	6.10	ZZZ
67332	.....	A	Rerevise eye muscles add-on	4.48	NA	2.03	0.23	NA	6.74	ZZZ
67334	.....	A	Revise eye muscle w/suture	3.97	NA	1.80	0.20	NA	5.97	ZZZ
67335	.....	A	Eye suture during surgery	2.49	NA	1.12	0.13	NA	3.74	ZZZ
67340	.....	A	Revise eye muscle add-on	4.92	NA	2.21	0.25	NA	7.38	ZZZ
67343	.....	A	Release eye tissue	7.34	NA	6.53	0.37	NA	14.24	090
67345	.....	A	Destroy nerve of eye muscle	2.96	2.59	2.02	0.17	5.72	5.15	010
67350	.....	A	Biopsy eye muscle	2.87	NA	1.88	0.15	NA	4.90	000
67399	.....	C	Eye muscle surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
67400	.....	A	Explore/biopsy eye socket	9.75	NA	11.29	0.56	NA	21.60	090
67405	.....	A	Explore/drain eye socket	7.92	NA	9.80	0.44	NA	18.16	090
67412	.....	A	Explore/treat eye socket	9.49	NA	10.96	0.48	NA	20.93	090
67413	.....	A	Explore/treat eye socket	9.99	NA	10.80	0.50	NA	21.29	090
67414	.....	A	Explr/decompress eye socket	11.11	NA	12.07	0.65	NA	23.83	090
67415	.....	A	Aspiration, orbital contents	1.76	NA	0.76	0.09	NA	2.61	000
67420	.....	A	Explore/treat eye socket	20.03	NA	17.44	1.15	NA	38.62	090
67430	.....	A	Explore/treat eye socket	13.37	NA	14.93	0.86	NA	29.16	090
67440	.....	A	Explore/drain eye socket	13.07	NA	14.30	0.70	NA	28.07	090
67445	.....	A	Explr/decompress eye socket	14.40	NA	13.95	0.90	NA	29.25	090
67450	.....	A	Explore/biopsy eye socket	13.49	NA	14.73	0.68	NA	28.90	090
67500	.....	A	Inject/treat eye socket	0.79	0.67	0.29	0.05	1.51	1.13	000
67505	.....	A	Inject/treat eye socket	0.82	0.69	0.31	0.05	1.56	1.18	000
67515	.....	A	Inject/treat eye socket	0.61	0.59	0.38	0.03	1.23	1.02	000
67550	.....	A	Insert eye socket implant	10.17	NA	11.33	0.72	NA	22.22	090
67560	.....	A	Revise eye socket implant	10.58	NA	11.40	0.60	NA	22.58	090
67570	.....	A	Decompress optic nerve	13.56	NA	13.62	0.68	NA	27.86	090
67599	.....	C	Orbit surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
67700	.....	A	Drainage of eyelid abscess	1.35	6.04	1.27	0.07	7.46	2.69	010
67710	.....	A	Incision of eyelid	1.02	5.39	1.21	0.05	6.46	2.28	010
67715	.....	A	Incision of eyelid fold	1.22	5.39	1.29	0.06	6.67	2.57	010
67800	.....	A	Remove eyelid lesion	1.38	1.62	1.04	0.07	3.07	2.49	010
67801	.....	A	Remove eyelid lesions	1.88	1.97	1.26	0.09	3.94	3.23	010
67805	.....	A	Remove eyelid lesions	2.22	2.53	1.65	0.11	4.86	3.98	010
67808	.....	A	Remove eyelid lesion(s)	3.79	NA	3.78	0.19	NA	7.76	090
67810	.....	A	Biopsy of eyelid	1.48	3.34	0.68	0.06	4.88	2.22	000
67820	.....	A	Revise eyelashes	0.89	0.60	0.56	0.04	1.53	1.49	000
67825	.....	A	Revise eyelashes	1.38	1.74	1.41	0.07	3.19	2.86	010
67830	.....	A	Revise eyelashes	1.70	5.55	1.50	0.08	7.33	3.28	010
67835	.....	A	Revise eyelashes	5.55	NA	4.63	0.28	NA	10.46	090
67840	.....	A	Remove eyelid lesion	2.04	5.49	1.65	0.10	7.63	3.79	010
67850	.....	A	Treat eyelid lesion	1.69	3.38	1.47	0.07	5.14	3.23	010
67875	.....	A	Closure of eyelid by suture	1.35	3.31	0.94	0.07	4.73	2.36	000
67880	.....	A	Revision of eyelid	3.79	6.63	3.81	0.19	10.61	7.79	090
67882	.....	A	Revision of eyelid	5.06	7.65	4.82	0.25	12.96	10.13	090
67900	.....	A	Repair brow defect	6.13	9.09	5.27	0.38	15.60	11.78	090
67901	.....	A	Repair eyelid defect	7.39	NA	5.42	0.54	NA	13.35	090
67902	.....	A	Repair eyelid defect	9.35	NA	5.48	0.60	NA	15.43	090
67903	.....	A	Repair eyelid defect	6.36	9.59	5.53	0.47	16.42	12.36	090
67904	.....	A	Repair eyelid defect	6.25	9.66	5.25	0.41	16.32	11.91	090
67906	.....	A	Repair eyelid defect	6.78	5.39	5.04	0.46	12.63	12.28	090
67908	.....	A	Repair eyelid defect	5.12	6.65	5.36	0.28	12.05	10.76	090
67909	.....	A	Revise eyelid defect	5.39	8.05	4.96	0.31	13.75	10.66	090
67911	.....	A	Revise eyelid defect	5.26	NA	4.79	0.31	NA	10.36	090
67912	.....	A	Correction eyelid w/implant	5.67	18.98	5.55	0.28	24.93	11.50	090
67914	.....	A	Repair eyelid defect	3.67	6.36	3.06	0.19	10.22	6.92	090
67915	.....	A	Repair eyelid defect	3.18	6.00	2.81	0.16	9.34	6.15	090
67916	.....	A	Repair eyelid defect	5.30	8.07	4.77	0.28	13.65	10.35	090
67917	.....	A	Repair eyelid defect	6.01	8.48	5.08	0.36	14.85	11.45	090
67921	.....	A	Repair eyelid defect	3.39	6.21	2.90	0.17	9.77	6.46	090
67922	.....	A	Repair eyelid defect	3.06	5.93	2.76	0.15	9.14	5.97	090
67923	.....	A	Repair eyelid defect	5.87	8.14	4.98	0.30	14.31	11.15	090
67924	.....	A	Repair eyelid defect	5.78	8.95	4.69	0.30	15.03	10.77	090
67930	.....	A	Repair eyelid wound	3.60	5.73	2.18	0.19	9.52	5.97	010
67935	.....	A	Repair eyelid wound	6.21	8.54	4.42	0.39	15.14	11.02	090
67938	.....	A	Remove eyelid foreign body	1.33	5.40	1.26	0.06	6.79	2.65	010

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
67950	.....	A	Revision of eyelid	5.81	8.66	5.23	0.36	14.83	11.40	090
67961	.....	A	Revision of eyelid	5.68	8.71	5.04	0.33	14.72	11.05	090
67966	.....	A	Revision of eyelid	6.56	9.16	5.58	0.37	16.09	12.51	090
67971	.....	A	Reconstruction of eyelid	9.78	NA	7.30	0.53	NA	17.61	090
67973	.....	A	Reconstruction of eyelid	12.85	NA	9.34	0.75	NA	22.94	090
67974	.....	A	Reconstruction of eyelid	12.82	NA	9.26	0.75	NA	22.83	090
67975	.....	A	Reconstruction of eyelid	9.12	NA	6.97	0.50	NA	16.59	090
67999	.....	C	Revision of eyelid	0.00	0.00	0.00	0.00	0.00	0.00	YYY
68020	.....	A	Incise/drain eyelid lining	1.37	1.41	1.21	0.06	2.84	2.64	010
68040	.....	A	Treatment of eyelid lesions	0.85	0.71	0.43	0.04	1.60	1.32	000
68100	.....	A	Biopsy of eyelid lining	1.35	3.26	0.95	0.07	4.68	2.37	000
68110	.....	A	Remove eyelid lining lesion	1.77	4.11	1.65	0.09	5.97	3.51	010
68115	.....	A	Remove eyelid lining lesion	2.36	5.98	1.92	0.12	8.46	4.40	010
68130	.....	A	Remove eyelid lining lesion	4.92	8.74	4.61	0.24	13.90	9.77	090
68135	.....	A	Remove eyelid lining lesion	1.84	1.82	1.65	0.09	3.75	3.58	010
68200	.....	A	Treat eyelid by injection	0.49	0.54	0.33	0.02	1.05	0.84	000
68320	.....	A	Revise/graft eyelid lining	5.36	11.31	5.54	0.27	16.94	11.17	090
68325	.....	A	Revise/graft eyelid lining	7.35	NA	6.56	0.44	NA	14.35	090
68326	.....	A	Revise/graft eyelid lining	7.14	NA	6.43	0.35	NA	13.92	090
68328	.....	A	Revise/graft eyelid lining	8.17	NA	7.31	0.54	NA	16.02	090
68330	.....	A	Revise eyelid lining	4.82	9.44	4.73	0.24	14.50	9.79	090
68335	.....	A	Revise/graft eyelid lining	7.18	NA	6.40	0.36	NA	13.94	090
68340	.....	A	Separate eyelid adhesions	4.16	8.90	4.11	0.21	13.27	8.48	090
68360	.....	A	Revise eyelid lining	4.36	8.06	4.19	0.22	12.64	8.77	090
68362	.....	A	Revise eyelid lining	7.33	NA	6.42	0.36	NA	14.11	090
68371	.....	A	Harvest eye tissue, alograft	4.89	NA	4.74	0.44	NA	10.07	010
68399	.....	C	Eyelid lining surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
68400	.....	A	Incise/drain tear gland	1.69	5.92	1.83	0.08	7.69	3.60	010
68420	.....	A	Incise/drain tear sac	2.30	6.21	2.11	0.11	8.62	4.52	010
68440	.....	A	Incise tear duct opening	0.94	2.09	1.27	0.05	3.08	2.26	010
68500	.....	A	Removal of tear gland	11.00	NA	9.76	0.55	NA	21.31	090
68505	.....	A	Partial removal, tear gland	10.92	NA	10.68	0.55	NA	22.15	090
68510	.....	A	Biopsy of tear gland	4.60	7.35	2.10	0.23	12.18	6.93	000
68520	.....	A	Removal of tear sac	7.50	NA	7.44	0.37	NA	15.31	090
68525	.....	A	Biopsy of tear sac	4.42	NA	2.03	0.22	NA	6.67	000
68530	.....	A	Clearance of tear duct	3.65	8.19	2.65	0.18	12.02	6.48	010
68540	.....	A	Remove tear gland lesion	10.58	NA	9.42	0.52	NA	20.52	090
68550	.....	A	Remove tear gland lesion	13.24	NA	11.38	0.80	NA	25.42	090
68700	.....	A	Repair tear ducts	6.59	NA	6.00	0.32	NA	12.91	090
68705	.....	A	Revise tear duct opening	2.06	4.18	1.80	0.10	6.34	3.96	010
68720	.....	A	Create tear sac drain	8.95	NA	7.88	0.44	NA	17.27	090
68745	.....	A	Create tear duct drain	8.62	NA	7.88	0.52	NA	17.02	090
68750	.....	A	Create tear duct drain	8.65	NA	8.29	0.43	NA	17.37	090
68760	.....	A	Close tear duct opening	1.73	3.55	1.63	0.09	5.37	3.45	010
68761	.....	A	Close tear duct opening	1.36	2.28	1.32	0.06	3.70	2.74	010
68770	.....	A	Close tear system fistula	7.01	3.19	3.19	0.35	10.55	10.55	090
68801	.....	A	Dilate tear duct opening	0.94	1.95	1.48	0.05	2.94	2.47	010
68810	.....	A	Probe nasolacrimal duct	1.90	3.67	2.68	0.10	5.67	4.68	010
68811	.....	A	Probe nasolacrimal duct	2.35	NA	2.42	0.13	NA	4.90	010
68815	.....	A	Probe nasolacrimal duct	3.20	8.26	2.82	0.17	11.63	6.19	010
68840	.....	A	Explore/irrigate tear ducts	1.25	1.60	1.12	0.06	2.91	2.43	010
68850	.....	A	Injection for tear sac x-ray	0.80	0.88	0.68	0.04	1.72	1.52	000
68899	.....	C	Tear duct system surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69000	.....	A	Drain external ear lesion	1.45	2.89	1.36	0.12	4.46	2.93	010
69005	.....	A	Drain external ear lesion	2.11	2.94	1.84	0.17	5.22	4.12	010
69020	.....	A	Drain outer ear canal lesion	1.48	4.00	2.07	0.12	5.60	3.67	010
69090	.....	N	Pierce earlobes	0.00	0.00	0.00	0.00	0.00	0.00	XXX
69100	.....	A	Biopsy of external ear	0.81	1.71	0.39	0.03	2.55	1.23	000
69105	.....	A	Biopsy of external ear canal	0.85	2.35	0.77	0.07	3.27	1.69	000
69110	.....	A	Remove external ear, partial	3.43	6.76	4.48	0.30	10.49	8.21	090
69120	.....	A	Removal of external ear	4.04	NA	6.20	0.38	NA	10.62	090
69140	.....	A	Remove ear canal lesion(s)	7.96	NA	13.32	0.65	NA	21.93	090
69145	.....	A	Remove ear canal lesion(s)	2.62	5.80	3.31	0.21	8.63	6.14	090
69150	.....	A	Extensive ear canal surgery	13.41	NA	13.44	1.22	NA	28.07	090
69155	.....	A	Extensive ear/neck surgery	20.77	NA	19.60	1.92	NA	42.29	090
69200	.....	A	Clear outer ear canal	0.77	2.39	0.55	0.06	3.22	1.38	000
69205	.....	A	Clear outer ear canal	1.20	NA	1.36	0.10	NA	2.66	010
69210	.....	A	Remove impacted ear wax	0.61	0.63	0.23	0.05	1.29	0.89	000
69220	.....	A	Clean out mastoid cavity	0.83	2.37	0.73	0.07	3.27	1.63	000
69222	.....	A	Clean out mastoid cavity	1.40	3.86	2.07	0.12	5.38	3.59	010
69300	.....	R	Revise external ear	6.35	NA	4.23	0.72	NA	11.30	YYY
69310	.....	A	Rebuild outer ear canal	10.77	NA	16.33	0.85	NA	27.95	090
69320	.....	A	Rebuild outer ear canal	16.93	NA	21.90	1.37	NA	40.20	090
69399	.....	C	Outer ear surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69400	.....	A	Inflate middle ear canal	0.83	2.17	0.67	0.07	3.07	1.57	000

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
69401	.....	A	Inflate middle ear canal	0.63	1.24	0.65	0.05	1.92	1.33	000
69405	.....	A	Catheterize middle ear canal	2.63	3.51	2.32	0.21	6.35	5.16	010
69420	.....	A	Incision of eardrum	1.33	3.16	1.59	0.11	4.60	3.03	010
69421	.....	A	Incision of eardrum	1.73	NA	2.17	0.15	NA	4.05	010
69424	.....	A	Remove ventilating tube	0.85	2.19	0.68	0.07	3.11	1.60	000
69433	.....	A	Create eardrum opening	1.52	3.10	1.64	0.13	4.75	3.29	010
69436	.....	A	Create eardrum opening	1.96	NA	2.30	0.19	NA	4.45	010
69440	.....	A	Exploration of middle ear	7.56	NA	8.80	0.61	NA	16.97	090
69450	.....	A	Eardrum revision	5.56	NA	7.05	0.45	NA	13.06	090
69501	.....	A	Mastoidectomy	9.06	NA	9.03	0.73	NA	18.82	090
69502	.....	A	Mastoidectomy	12.36	NA	11.62	1.00	NA	24.98	090
69505	.....	A	Remove mastoid structures	12.97	NA	17.24	1.05	NA	31.26	090
69511	.....	A	Extensive mastoid surgery	13.50	NA	17.52	1.09	NA	32.11	090
69530	.....	A	Extensive mastoid surgery	19.16	NA	21.69	1.54	NA	42.39	090
69535	.....	A	Remove part of temporal bone	36.09	NA	32.05	2.92	NA	71.06	090
69540	.....	A	Remove ear lesion	1.20	3.75	1.98	0.10	5.05	3.28	010
69550	.....	A	Remove ear lesion	10.97	NA	14.90	0.89	NA	26.76	090
69552	.....	A	Remove ear lesion	19.43	NA	20.73	1.59	NA	41.75	090
69554	.....	A	Remove ear lesion	33.11	NA	30.42	2.91	NA	66.44	090
69601	.....	A	Mastoid surgery revision	13.22	NA	12.71	1.07	NA	27.00	090
69602	.....	A	Mastoid surgery revision	13.56	NA	13.27	1.10	NA	27.93	090
69603	.....	A	Mastoid surgery revision	14.00	NA	18.41	1.14	NA	33.55	090
69604	.....	A	Mastoid surgery revision	14.00	NA	13.73	1.14	NA	28.87	090
69605	.....	A	Mastoid surgery revision	18.46	NA	21.01	1.50	NA	40.97	090
69610	.....	A	Repair of eardrum	4.42	5.57	3.28	0.36	10.35	8.06	010
69620	.....	A	Repair of eardrum	5.88	11.15	6.31	0.48	17.51	12.67	090
69631	.....	A	Repair eardrum structures	9.85	NA	11.23	0.80	NA	21.88	090
69632	.....	A	Rebuild eardrum structures	12.73	NA	13.51	1.03	NA	27.27	090
69633	.....	A	Rebuild eardrum structures	12.08	NA	13.09	0.98	NA	26.15	090
69635	.....	A	Repair eardrum structures	13.31	NA	16.79	1.08	NA	31.18	090
69636	.....	A	Rebuild eardrum structures	15.20	NA	19.36	1.23	NA	35.79	090
69637	.....	A	Rebuild eardrum structures	15.09	NA	19.28	1.22	NA	35.59	090
69641	.....	A	Revise middle ear & mastoid	12.69	NA	12.82	1.03	NA	26.54	090
69642	.....	A	Revise middle ear & mastoid	16.81	NA	16.33	1.36	NA	34.50	090
69643	.....	A	Revise middle ear & mastoid	15.30	NA	14.86	1.24	NA	31.40	090
69644	.....	A	Revise middle ear & mastoid	16.94	NA	20.46	1.37	NA	38.77	090
69645	.....	A	Revise middle ear & mastoid	16.36	NA	20.08	1.33	NA	37.77	090
69646	.....	A	Revise middle ear & mastoid	17.96	NA	20.82	1.46	NA	40.24	090
69650	.....	A	Release middle ear bone	9.65	NA	9.94	0.78	NA	20.37	090
69660	.....	A	Revise middle ear bone	11.88	NA	11.21	0.96	NA	24.05	090
69661	.....	A	Revise middle ear bone	15.72	NA	14.74	1.27	NA	31.73	090
69662	.....	A	Revise middle ear bone	15.42	NA	13.79	1.25	NA	30.46	090
69666	.....	A	Repair middle ear structures	9.74	NA	10.00	0.79	NA	20.53	090
69667	.....	A	Repair middle ear structures	9.75	NA	10.01	0.79	NA	20.55	090
69670	.....	A	Remove mastoid air cells	11.49	NA	11.74	0.93	NA	24.16	090
69676	.....	A	Remove middle ear nerve	9.51	NA	10.78	0.81	NA	21.10	090
69700	.....	A	Close mastoid fistula	8.22	NA	9.27	0.67	NA	18.16	090
69710	.....	N	Implant/replace hearing aid	0.00	0.00	0.00	0.00	0.00	0.00	XXX
69711	.....	A	Remove/repair hearing aid	10.42	NA	10.82	0.83	NA	22.07	090
69714	.....	A	Implant temple bone w/stimul	13.98	NA	12.70	1.13	NA	27.81	090
69715	.....	A	Temple bne implnt w/stimulat	18.22	NA	15.07	1.48	NA	34.77	090
69717	.....	A	Temple bone implant revision	14.96	NA	14.51	0.90	NA	30.37	090
69718	.....	A	Revise temple bone implant	18.47	NA	15.34	3.21	NA	37.02	090
69720	.....	A	Release facial nerve	14.36	NA	14.56	1.16	NA	30.08	090
69725	.....	A	Release facial nerve	25.34	NA	20.19	2.44	NA	47.97	090
69740	.....	A	Repair facial nerve	15.94	NA	13.45	1.27	NA	30.66	090
69745	.....	A	Repair facial nerve	16.66	NA	15.01	1.14	NA	32.81	090
69799	.....	C	Middle ear surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69801	.....	A	Incise inner ear	8.55	NA	9.49	0.69	NA	18.73	090
69802	.....	A	Incise inner ear	13.08	NA	12.36	1.06	NA	26.50	090
69805	.....	A	Explore inner ear	13.80	NA	11.91	1.12	NA	26.83	090
69806	.....	A	Explore inner ear	12.33	NA	11.07	1.00	NA	24.40	090
69820	.....	A	Establish inner ear window	10.32	NA	11.25	0.90	NA	22.47	090
69840	.....	A	Revise inner ear window	10.24	NA	13.21	0.79	NA	24.24	090
69905	.....	A	Remove inner ear	11.08	NA	11.38	0.90	NA	23.36	090
69910	.....	A	Remove inner ear & mastoid	13.61	NA	11.95	1.07	NA	26.63	090
69915	.....	A	Incise inner ear nerve	21.20	NA	16.51	1.69	NA	39.40	090
69930	.....	A	Implant cochlear device	16.78	NA	14.79	1.36	NA	32.93	090
69949	.....	C	Inner ear surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69950	.....	A	Incise inner ear nerve	25.60	NA	18.95	2.28	NA	46.83	090
69955	.....	A	Release facial nerve	27.00	NA	21.44	2.48	NA	50.92	090
69960	.....	A	Release inner ear canal	27.00	NA	20.11	2.17	NA	49.28	090
69970	.....	A	Remove inner ear lesion	29.99	NA	23.34	2.41	NA	55.74	090
69979	.....	C	Temporal bone surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69990	.....	R	Microsurgery add-on	3.46	NA	1.80	0.89	NA	6.15	ZZZ

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
70010	26	A	Contrast x-ray of brain	1.19	0.39	0.39	0.05	1.63	1.63	XXX
70010	TC	A	Contrast x-ray of brain	0.00	4.34	NA	0.22	4.56	NA	XXX
70010	.....	A	Contrast x-ray of brain	1.19	4.73	NA	0.27	6.19	NA	XXX
70015	26	A	Contrast x-ray of brain	1.19	0.39	0.39	0.08	1.66	1.66	XXX
70015	TC	A	Contrast x-ray of brain	0.00	1.35	NA	0.08	1.43	NA	XXX
70015	.....	A	Contrast x-ray of brain	1.19	1.74	NA	0.16	3.09	NA	XXX
70030	26	A	X-ray eye for foreign body	0.17	0.06	0.06	0.01	0.24	0.24	XXX
70030	TC	A	X-ray eye for foreign body	0.00	0.42	NA	0.02	0.44	NA	XXX
70030	.....	A	X-ray eye for foreign body	0.17	0.48	NA	0.03	0.68	NA	XXX
70100	26	A	X-ray exam of jaw	0.18	0.06	0.06	0.01	0.25	0.25	XXX
70100	TC	A	X-ray exam of jaw	0.00	0.52	NA	0.02	0.54	NA	XXX
70100	.....	A	X-ray exam of jaw	0.18	0.58	NA	0.03	0.79	NA	XXX
70110	26	A	X-ray exam of jaw	0.25	0.08	0.08	0.01	0.34	0.34	XXX
70110	TC	A	X-ray exam of jaw	0.00	0.62	NA	0.04	0.66	NA	XXX
70110	.....	A	X-ray exam of jaw	0.25	0.70	NA	0.05	1.00	NA	XXX
70120	26	A	X-ray exam of mastoids	0.18	0.06	0.06	0.01	0.25	0.25	XXX
70120	TC	A	X-ray exam of mastoids	0.00	0.62	NA	0.04	0.66	NA	XXX
70120	.....	A	X-ray exam of mastoids	0.18	0.68	NA	0.05	0.91	NA	XXX
70130	26	A	X-ray exam of mastoids	0.34	0.11	0.11	0.02	0.47	0.47	XXX
70130	TC	A	X-ray exam of mastoids	0.00	0.78	NA	0.05	0.83	NA	XXX
70130	.....	A	X-ray exam of mastoids	0.34	0.89	NA	0.07	1.30	NA	XXX
70134	26	A	X-ray exam of middle ear	0.34	0.11	0.11	0.02	0.47	0.47	XXX
70134	TC	A	X-ray exam of middle ear	0.00	0.73	NA	0.05	0.78	NA	XXX
70134	.....	A	X-ray exam of middle ear	0.34	0.84	NA	0.07	1.25	NA	XXX
70140	26	A	X-ray exam of facial bones	0.19	0.06	0.06	0.01	0.26	0.26	XXX
70140	TC	A	X-ray exam of facial bones	0.00	0.62	NA	0.04	0.66	NA	XXX
70140	.....	A	X-ray exam of facial bones	0.19	0.68	NA	0.05	0.92	NA	XXX
70150	26	A	X-ray exam of facial bones	0.26	0.08	0.08	0.01	0.35	0.35	XXX
70150	TC	A	X-ray exam of facial bones	0.00	0.78	NA	0.05	0.83	NA	XXX
70150	.....	A	X-ray exam of facial bones	0.26	0.86	NA	0.06	1.18	NA	XXX
70160	26	A	X-ray exam of nasal bones	0.17	0.06	0.06	0.01	0.24	0.24	XXX
70160	TC	A	X-ray exam of nasal bones	0.00	0.52	NA	0.02	0.54	NA	XXX
70160	.....	A	X-ray exam of nasal bones	0.17	0.58	NA	0.03	0.78	NA	XXX
70170	26	A	X-ray exam of tear duct	0.30	0.10	0.10	0.01	0.41	0.41	XXX
70170	TC	A	X-ray exam of tear duct	0.00	0.95	NA	0.06	1.01	NA	XXX
70170	.....	A	X-ray exam of tear duct	0.30	1.05	NA	0.07	1.42	NA	XXX
70190	26	A	X-ray exam of eye sockets	0.21	0.07	0.07	0.01	0.29	0.29	XXX
70190	TC	A	X-ray exam of eye sockets	0.00	0.62	NA	0.04	0.66	NA	XXX
70190	.....	A	X-ray exam of eye sockets	0.21	0.69	NA	0.05	0.95	NA	XXX
70200	26	A	X-ray exam of eye sockets	0.28	0.09	0.09	0.01	0.38	0.38	XXX
70200	TC	A	X-ray exam of eye sockets	0.00	0.78	NA	0.05	0.83	NA	XXX
70200	.....	A	X-ray exam of eye sockets	0.28	0.87	NA	0.06	1.21	NA	XXX
70210	26	A	X-ray exam of sinuses	0.17	0.06	0.06	0.01	0.24	0.24	XXX
70210	TC	A	X-ray exam of sinuses	0.00	0.62	NA	0.04	0.66	NA	XXX
70210	.....	A	X-ray exam of sinuses	0.17	0.68	NA	0.05	0.90	NA	XXX
70220	26	A	X-ray exam of sinuses	0.25	0.08	0.08	0.01	0.34	0.34	XXX
70220	TC	A	X-ray exam of sinuses	0.00	0.78	NA	0.05	0.83	NA	XXX
70220	.....	A	X-ray exam of sinuses	0.25	0.86	NA	0.06	1.17	NA	XXX
70240	26	A	X-ray exam, pituitary saddle	0.19	0.06	0.06	0.01	0.26	0.26	XXX
70240	TC	A	X-ray exam, pituitary saddle	0.00	0.42	NA	0.02	0.44	NA	XXX
70240	.....	A	X-ray exam, pituitary saddle	0.19	0.48	NA	0.03	0.70	NA	XXX
70250	26	A	X-ray exam of skull	0.24	0.08	0.08	0.01	0.33	0.33	XXX
70250	TC	A	X-ray exam of skull	0.00	0.62	NA	0.04	0.66	NA	XXX
70250	.....	A	X-ray exam of skull	0.24	0.70	NA	0.05	0.99	NA	XXX
70260	26	A	X-ray exam of skull	0.34	0.11	0.11	0.02	0.47	0.47	XXX
70260	TC	A	X-ray exam of skull	0.00	0.89	NA	0.06	0.95	NA	XXX
70260	.....	A	X-ray exam of skull	0.34	1.00	NA	0.08	1.42	NA	XXX
70300	26	A	X-ray exam of teeth	0.10	0.05	0.05	0.01	0.16	0.16	XXX
70300	TC	A	X-ray exam of teeth	0.00	0.26	NA	0.02	0.28	NA	XXX
70300	.....	A	X-ray exam of teeth	0.10	0.31	NA	0.03	0.44	NA	XXX
70310	26	A	X-ray exam of teeth	0.16	0.08	0.08	0.01	0.25	0.25	XXX
70310	TC	A	X-ray exam of teeth	0.00	0.42	NA	0.02	0.44	NA	XXX
70310	.....	A	X-ray exam of teeth	0.16	0.50	NA	0.03	0.69	NA	XXX
70320	26	A	Full mouth x-ray of teeth	0.22	0.08	0.08	0.01	0.31	0.31	XXX
70320	TC	A	Full mouth x-ray of teeth	0.00	0.78	NA	0.05	0.83	NA	XXX
70320	.....	A	Full mouth x-ray of teeth	0.22	0.86	NA	0.06	1.14	NA	XXX
70328	26	A	X-ray exam of jaw joint	0.18	0.06	0.06	0.01	0.25	0.25	XXX
70328	TC	A	X-ray exam of jaw joint	0.00	0.49	NA	0.02	0.51	NA	XXX
70328	.....	A	X-ray exam of jaw joint	0.18	0.55	NA	0.03	0.76	NA	XXX
70330	26	A	X-ray exam of jaw joints	0.24	0.08	0.08	0.01	0.33	0.33	XXX
70330	TC	A	X-ray exam of jaw joints	0.00	0.84	NA	0.05	0.89	NA	XXX
70330	.....	A	X-ray exam of jaw joints	0.24	0.92	NA	0.06	1.22	NA	XXX
70332	26	A	X-ray exam of jaw joint	0.54	0.20	0.20	0.02	0.76	0.76	XXX
70332	TC	A	X-ray exam of jaw joint	0.00	2.11	NA	0.12	2.23	NA	XXX
70332	.....	A	X-ray exam of jaw joint	0.54	2.31	NA	0.14	2.99	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
70336	26	A	Magnetic image, jaw joint	1.48	0.49	0.49	0.07	2.04	2.04	XXX
70336	TC	A	Magnetic image, jaw joint	0.00	11.23	NA	0.59	11.82	NA	XXX
70336	.....	A	Magnetic image, jaw joint	1.48	11.72	NA	0.66	13.86	NA	XXX
70350	26	A	X-ray head for orthodontia	0.17	0.07	0.07	0.01	0.25	0.25	XXX
70350	TC	A	X-ray head for orthodontia	0.00	0.38	NA	0.02	0.40	NA	XXX
70350	.....	A	X-ray head for orthodontia	0.17	0.45	NA	0.03	0.65	NA	XXX
70355	26	A	Panoramic x-ray of jaws	0.20	0.07	0.07	0.01	0.28	0.28	XXX
70355	TC	A	Panoramic x-ray of jaws	0.00	0.57	NA	0.04	0.61	NA	XXX
70355	.....	A	Panoramic x-ray of jaws	0.20	0.64	NA	0.05	0.89	NA	XXX
70360	26	A	X-ray exam of neck	0.17	0.06	0.06	0.01	0.24	0.24	XXX
70360	TC	A	X-ray exam of neck	0.00	0.42	NA	0.02	0.44	NA	XXX
70360	.....	A	X-ray exam of neck	0.17	0.48	NA	0.03	0.68	NA	XXX
70370	26	A	Throat x-ray & fluoroscopy	0.32	0.10	0.10	0.01	0.43	0.43	XXX
70370	TC	A	Throat x-ray & fluoroscopy	0.00	1.31	NA	0.07	1.38	NA	XXX
70370	.....	A	Throat x-ray & fluoroscopy	0.32	1.41	NA	0.08	1.81	NA	XXX
70371	26	A	Speech evaluation, complex	0.84	0.28	0.28	0.04	1.16	1.16	XXX
70371	TC	A	Speech evaluation, complex	0.00	2.11	NA	0.12	2.23	NA	XXX
70371	.....	A	Speech evaluation, complex	0.84	2.39	NA	0.16	3.39	NA	XXX
70373	26	A	Contrast x-ray of larynx	0.44	0.14	0.14	0.02	0.60	0.60	XXX
70373	TC	A	Contrast x-ray of larynx	0.00	1.79	NA	0.11	1.90	NA	XXX
70373	.....	A	Contrast x-ray of larynx	0.44	1.93	NA	0.13	2.50	NA	XXX
70380	26	A	X-ray exam of salivary gland	0.17	0.06	0.06	0.01	0.24	0.24	XXX
70380	TC	A	X-ray exam of salivary gland	0.00	0.67	NA	0.04	0.71	NA	XXX
70380	.....	A	X-ray exam of salivary gland	0.17	0.73	NA	0.05	0.95	NA	XXX
70390	26	A	X-ray exam of salivary duct	0.38	0.12	0.12	0.02	0.52	0.52	XXX
70390	TC	A	X-ray exam of salivary duct	0.00	1.79	NA	0.11	1.90	NA	XXX
70390	.....	A	X-ray exam of salivary duct	0.38	1.91	NA	0.13	2.42	NA	XXX
70450	26	A	Ct head/brain w/o dye	0.85	0.28	0.28	0.04	1.17	1.17	XXX
70450	TC	A	Ct head/brain w/o dye	0.00	4.73	NA	0.25	4.98	NA	XXX
70450	.....	A	Ct head/brain w/o dye	0.85	5.01	NA	0.29	6.15	NA	XXX
70460	26	A	Ct head/brain w/dye	1.13	0.37	0.37	0.05	1.55	1.55	XXX
70460	TC	A	Ct head/brain w/dye	0.00	5.68	NA	0.30	5.98	NA	XXX
70460	.....	A	Ct head/brain w/dye	1.13	6.05	NA	0.35	7.53	NA	XXX
70470	26	A	Ct head/brain w/o & w/dye	1.27	0.42	0.42	0.06	1.75	1.75	XXX
70470	TC	A	Ct head/brain w/o & w/dye	0.00	7.09	NA	0.37	7.46	NA	XXX
70470	.....	A	Ct head/brain w/o & w/dye	1.27	7.51	NA	0.43	9.21	NA	XXX
70480	26	A	Ct orbit/ear/fossa w/o dye	1.28	0.42	0.42	0.06	1.76	1.76	XXX
70480	TC	A	Ct orbit/ear/fossa w/o dye	0.00	4.73	NA	0.25	4.98	NA	XXX
70480	.....	A	Ct orbit/ear/fossa w/o dye	1.28	5.15	NA	0.31	6.74	NA	XXX
70481	26	A	Ct orbit/ear/fossa w/dye	1.38	0.45	0.45	0.06	1.89	1.89	XXX
70481	TC	A	Ct orbit/ear/fossa w/dye	0.00	5.68	NA	0.30	5.98	NA	XXX
70481	.....	A	Ct orbit/ear/fossa w/dye	1.38	6.13	NA	0.36	7.87	NA	XXX
70482	26	A	Ct orbit/ear/fossa w/o&w/dye	1.45	0.48	0.48	0.06	1.99	1.99	XXX
70482	TC	A	Ct orbit/ear/fossa w/o&w/dye	0.00	7.09	NA	0.37	7.46	NA	XXX
70482	.....	A	Ct orbit/ear/fossa w/o&w/dye	1.45	7.57	NA	0.43	9.45	NA	XXX
70486	26	A	Ct maxillofacial w/o dye	1.14	0.37	0.37	0.05	1.56	1.56	XXX
70486	TC	A	Ct maxillofacial w/o dye	0.00	4.73	NA	0.25	4.98	NA	XXX
70486	.....	A	Ct maxillofacial w/o dye	1.14	5.10	NA	0.30	6.54	NA	XXX
70487	26	A	Ct maxillofacial w/dye	1.30	0.43	0.43	0.06	1.79	1.79	XXX
70487	TC	A	Ct maxillofacial w/dye	0.00	5.68	NA	0.30	5.98	NA	XXX
70487	.....	A	Ct maxillofacial w/dye	1.30	6.11	NA	0.36	7.77	NA	XXX
70488	26	A	Ct maxillofacial w/o & w/dye	1.42	0.46	0.46	0.06	1.94	1.94	XXX
70488	TC	A	Ct maxillofacial w/o & w/dye	0.00	7.09	NA	0.37	7.46	NA	XXX
70488	.....	A	Ct maxillofacial w/o & w/dye	1.42	7.55	NA	0.43	9.40	NA	XXX
70490	26	A	Ct soft tissue neck w/o dye	1.28	0.42	0.42	0.06	1.76	1.76	XXX
70490	TC	A	Ct soft tissue neck w/o dye	0.00	4.73	NA	0.25	4.98	NA	XXX
70490	.....	A	Ct soft tissue neck w/o dye	1.28	5.15	NA	0.31	6.74	NA	XXX
70491	26	A	Ct soft tissue neck w/dye	1.38	0.45	0.45	0.06	1.89	1.89	XXX
70491	TC	A	Ct soft tissue neck w/dye	0.00	5.68	NA	0.30	5.98	NA	XXX
70491	.....	A	Ct soft tissue neck w/dye	1.38	6.13	NA	0.36	7.87	NA	XXX
70492	26	A	Ct sft tsue nck w/o & w/dye	1.45	0.47	0.47	0.06	1.98	1.98	XXX
70492	TC	A	Ct sft tsue nck w/o & w/dye	0.00	7.09	NA	0.37	7.46	NA	XXX
70492	.....	A	Ct sft tsue nck w/o & w/dye	1.45	7.56	NA	0.43	9.44	NA	XXX
70496	26	A	Ct angiography, head	1.75	0.57	0.57	0.08	2.40	2.40	XXX
70496	TC	A	Ct angiography, head	0.00	10.63	NA	0.58	11.21	NA	XXX
70496	.....	A	Ct angiography, head	1.75	11.20	NA	0.66	13.61	NA	XXX
70498	26	A	Ct angiography, neck	1.75	0.57	0.57	0.08	2.40	2.40	XXX
70498	TC	A	Ct angiography, neck	0.00	10.63	NA	0.58	11.21	NA	XXX
70498	.....	A	Ct angiography, neck	1.75	11.20	NA	0.66	13.61	NA	XXX
70540	26	A	Mri orbit/face/neck w/o dye	1.35	0.44	0.44	0.06	1.85	1.85	XXX
70540	TC	A	Mri orbit/face/neck w/o dye	0.00	11.23	NA	0.39	11.62	NA	XXX
70540	.....	A	Mri orbit/face/neck w/o dye	1.35	11.67	NA	0.45	13.47	NA	XXX
70542	26	A	Mri orbit/face/neck w/dye	1.62	0.53	0.53	0.07	2.22	2.22	XXX
70542	TC	A	Mri orbit/face/neck w/dye	0.00	13.48	NA	0.47	13.95	NA	XXX
70542	.....	A	Mri orbit/face/neck w/dye	1.62	14.01	NA	0.54	16.17	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
70543	26	A	Mri orbt/fac/nck w/o & w/dye	2.15	0.71	0.71	0.10	2.96	2.96	XXX
70543	TC	A	Mri orbt/fac/nck w/o & w/dye	0.00	24.95	NA	0.84	25.79	NA	XXX
70543		A	Mri orbt/fac/nck w/o & w/dye	2.15	25.66	NA	0.94	28.75	NA	XXX
70544	26	A	Mr angiography head w/o dye	1.20	0.40	0.40	0.05	1.65	1.65	XXX
70544	TC	A	Mr angiography head w/o dye	0.00	11.23	NA	0.59	11.82	NA	XXX
70544		A	Mr angiography head w/o dye	1.20	11.63	NA	0.64	13.47	NA	XXX
70545	26	A	Mr angiography head w/dye	1.20	0.39	0.39	0.05	1.64	1.64	XXX
70545	TC	A	Mr angiography head w/dye	0.00	11.23	NA	0.59	11.82	NA	XXX
70545		A	Mr angiography head w/dye	1.20	11.62	NA	0.64	13.46	NA	XXX
70546	26	A	Mr angiograph head w/o&w/dye	1.80	0.59	0.59	0.08	2.47	2.47	XXX
70546	TC	A	Mr angiograph head w/o&w/dye	0.00	22.47	NA	0.59	23.06	NA	XXX
70546		A	Mr angiograph head w/o&w/dye	1.80	23.06	NA	0.67	25.53	NA	XXX
70547	26	A	Mr angiography neck w/o dye	1.20	0.39	0.39	0.05	1.64	1.64	XXX
70547	TC	A	Mr angiography neck w/o dye	0.00	11.23	NA	0.59	11.82	NA	XXX
70547		A	Mr angiography neck w/o dye	1.20	11.62	NA	0.64	13.46	NA	XXX
70548	26	A	Mr angiography neck w/dye	1.20	0.39	0.39	0.05	1.64	1.64	XXX
70548	TC	A	Mr angiography neck w/dye	0.00	11.23	NA	0.59	11.82	NA	XXX
70548		A	Mr angiography neck w/dye	1.20	11.62	NA	0.64	13.46	NA	XXX
70549	26	A	Mr angiograph neck w/o&w/dye	1.80	0.59	0.59	0.08	2.47	2.47	XXX
70549	TC	A	Mr angiograph neck w/o&w/dye	0.00	22.47	NA	0.59	23.06	NA	XXX
70549		A	Mr angiograph neck w/o&w/dye	1.80	23.06	NA	0.67	25.53	NA	XXX
70551	26	A	Mri brain w/o dye	1.48	0.49	0.49	0.07	2.04	2.04	XXX
70551	TC	A	Mri brain w/o dye	0.00	11.23	NA	0.59	11.82	NA	XXX
70551		A	Mri brain w/o dye	1.48	11.72	NA	0.66	13.86	NA	XXX
70552	26	A	Mri brain w/dye	1.78	0.59	0.59	0.08	2.45	2.45	XXX
70552	TC	A	Mri brain w/dye	0.00	13.48	NA	0.70	14.18	NA	XXX
70552		A	Mri brain w/dye	1.78	14.07	NA	0.78	16.63	NA	XXX
70553	26	A	Mri brain w/o & w/dye	2.36	0.78	0.78	0.10	3.24	3.24	XXX
70553	TC	A	Mri brain w/o & w/dye	0.00	24.95	NA	1.31	26.26	NA	XXX
70553		A	Mri brain w/o & w/dye	2.36	25.73	NA	1.41	29.50	NA	XXX
70557	26	A	Mri brain w/o dye	2.90	1.13	1.13	0.08	4.11	4.11	XXX
70557	TC	C	Mri brain w/o dye	0.00	0.00	0.00	0.00	0.00	0.00	XXX
70557		C	Mri brain w/o dye	0.00	0.00	0.00	0.00	0.00	0.00	XXX
70558	26	A	Mri brain w/dye	3.20	1.24	1.24	0.10	4.54	4.54	XXX
70558	TC	C	Mri brain w/dye	0.00	0.00	0.00	0.00	0.00	0.00	XXX
70558		C	Mri brain w/dye	0.00	0.00	0.00	0.00	0.00	0.00	XXX
70559	26	A	Mri brain w/o & w/dye	3.20	1.24	1.24	0.12	4.56	4.56	XXX
70559	TC	C	Mri brain w/o & w/dye	0.00	0.00	0.00	0.00	0.00	0.00	XXX
70559		C	Mri brain w/o & w/dye	0.00	0.00	0.00	0.00	0.00	0.00	XXX
71010	26	A	Chest x-ray	0.18	0.06	0.06	0.01	0.25	0.25	XXX
71010	TC	A	Chest x-ray	0.00	0.47	NA	0.02	0.49	NA	XXX
71010		A	Chest x-ray	0.18	0.53	NA	0.03	0.74	NA	XXX
71015	26	A	Chest x-ray	0.21	0.07	0.07	0.01	0.29	0.29	XXX
71015	TC	A	Chest x-ray	0.00	0.52	NA	0.02	0.54	NA	XXX
71015		A	Chest x-ray	0.21	0.59	NA	0.03	0.83	NA	XXX
71020	26	A	Chest x-ray	0.22	0.07	0.07	0.01	0.30	0.30	XXX
71020	TC	A	Chest x-ray	0.00	0.62	NA	0.04	0.66	NA	XXX
71020		A	Chest x-ray	0.22	0.69	NA	0.05	0.96	NA	XXX
71021	26	A	Chest x-ray	0.27	0.09	0.09	0.01	0.37	0.37	XXX
71021	TC	A	Chest x-ray	0.00	0.73	NA	0.05	0.78	NA	XXX
71021		A	Chest x-ray	0.27	0.82	NA	0.06	1.15	NA	XXX
71022	26	A	Chest x-ray	0.31	0.10	0.10	0.01	0.42	0.42	XXX
71022	TC	A	Chest x-ray	0.00	0.73	NA	0.05	0.78	NA	XXX
71022		A	Chest x-ray	0.31	0.83	NA	0.06	1.20	NA	XXX
71023	26	A	Chest x-ray and fluoroscopy	0.38	0.13	0.13	0.01	0.52	0.52	XXX
71023	TC	A	Chest x-ray and fluoroscopy	0.00	0.78	NA	0.05	0.83	NA	XXX
71023		A	Chest x-ray and fluoroscopy	0.38	0.91	NA	0.06	1.35	NA	XXX
71030	26	A	Chest x-ray	0.31	0.10	0.10	0.01	0.42	0.42	XXX
71030	TC	A	Chest x-ray	0.00	0.78	NA	0.05	0.83	NA	XXX
71030		A	Chest x-ray	0.31	0.88	NA	0.06	1.25	NA	XXX
71034	26	A	Chest x-ray and fluoroscopy	0.46	0.16	0.16	0.02	0.64	0.64	XXX
71034	TC	A	Chest x-ray and fluoroscopy	0.00	1.44	NA	0.08	1.52	NA	XXX
71034		A	Chest x-ray and fluoroscopy	0.46	1.60	NA	0.10	2.16	NA	XXX
71035	26	A	Chest x-ray	0.18	0.06	0.06	0.01	0.25	0.25	XXX
71035	TC	A	Chest x-ray	0.00	0.52	NA	0.02	0.54	NA	XXX
71035		A	Chest x-ray	0.18	0.58	NA	0.03	0.79	NA	XXX
71040	26	A	Contrast x-ray of bronchi	0.58	0.19	0.19	0.03	0.80	0.80	XXX
71040	TC	A	Contrast x-ray of bronchi	0.00	1.46	NA	0.08	1.54	NA	XXX
71040		A	Contrast x-ray of bronchi	0.58	1.65	NA	0.11	2.34	NA	XXX
71060	26	A	Contrast x-ray of bronchi	0.74	0.24	0.24	0.03	1.01	1.01	XXX
71060	TC	A	Contrast x-ray of bronchi	0.00	2.21	NA	0.13	2.34	NA	XXX
71060		A	Contrast x-ray of bronchi	0.74	2.45	NA	0.16	3.35	NA	XXX
71090	26	A	X-ray & pacemaker insertion	0.54	0.21	0.21	0.02	0.77	0.77	XXX
71090	TC	A	X-ray & pacemaker insertion	0.00	1.68	NA	0.11	1.79	NA	XXX
71090		A	X-ray & pacemaker insertion	0.54	1.89	NA	0.13	2.56	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
71100	26	A	X-ray exam of ribs	0.22	0.07	0.07	0.01	0.30	0.30	XXX
71100	TC	A	X-ray exam of ribs	0.00	0.57	NA	0.04	0.61	NA	XXX
71100	.....	A	X-ray exam of ribs	0.22	0.64	NA	0.05	0.91	NA	XXX
71101	26	A	X-ray exam of ribs/chest	0.27	0.09	0.09	0.01	0.37	0.37	XXX
71101	TC	A	X-ray exam of ribs/chest	0.00	0.67	NA	0.04	0.71	NA	XXX
71101	.....	A	X-ray exam of ribs/chest	0.27	0.76	NA	0.05	1.08	NA	XXX
71110	26	A	X-ray exam of ribs	0.27	0.09	0.09	0.01	0.37	0.37	XXX
71110	TC	A	X-ray exam of ribs	0.00	0.78	NA	0.05	0.83	NA	XXX
71110	.....	A	X-ray exam of ribs	0.27	0.87	NA	0.06	1.20	NA	XXX
71111	26	A	X-ray exam of ribs/chest	0.32	0.10	0.10	0.01	0.43	0.43	XXX
71111	TC	A	X-ray exam of ribs/chest	0.00	0.89	NA	0.06	0.95	NA	XXX
71111	.....	A	X-ray exam of ribs/chest	0.32	0.99	NA	0.07	1.38	NA	XXX
71120	26	A	X-ray exam of breastbone	0.20	0.07	0.07	0.01	0.28	0.28	XXX
71120	TC	A	X-ray exam of breastbone	0.00	0.65	NA	0.04	0.69	NA	XXX
71120	.....	A	X-ray exam of breastbone	0.20	0.72	NA	0.05	0.97	NA	XXX
71130	26	A	X-ray exam of breastbone	0.22	0.07	0.07	0.01	0.30	0.30	XXX
71130	TC	A	X-ray exam of breastbone	0.00	0.71	NA	0.04	0.75	NA	XXX
71130	.....	A	X-ray exam of breastbone	0.22	0.78	NA	0.05	1.05	NA	XXX
71250	26	A	Ct thorax w/o dye	1.16	0.38	0.38	0.05	1.59	1.59	XXX
71250	TC	A	Ct thorax w/o dye	0.00	5.93	NA	0.31	6.24	NA	XXX
71250	.....	A	Ct thorax w/o dye	1.16	6.31	NA	0.36	7.83	NA	XXX
71260	26	A	Ct thorax w/dye	1.24	0.41	0.41	0.05	1.70	1.70	XXX
71260	TC	A	Ct thorax w/dye	0.00	7.09	NA	0.37	7.46	NA	XXX
71260	.....	A	Ct thorax w/dye	1.24	7.50	NA	0.42	9.16	NA	XXX
71270	26	A	Ct thorax w/o & w/dye	1.38	0.45	0.45	0.06	1.89	1.89	XXX
71270	TC	A	Ct thorax w/o & w/dye	0.00	8.88	NA	0.46	9.34	NA	XXX
71270	.....	A	Ct thorax w/o & w/dye	1.38	9.33	NA	0.52	11.23	NA	XXX
71275	26	A	Ct angiography, chest	1.92	0.63	0.63	0.09	2.64	2.64	XXX
71275	TC	A	Ct angiography, chest	0.00	12.42	NA	0.39	12.81	NA	XXX
71275	.....	A	Ct angiography, chest	1.92	13.05	NA	0.48	15.45	NA	XXX
71550	26	A	Mri chest w/o dye	1.46	0.48	0.48	0.06	2.00	2.00	XXX
71550	TC	A	Mri chest w/o dye	0.00	11.23	NA	0.45	11.68	NA	XXX
71550	.....	A	Mri chest w/o dye	1.46	11.71	NA	0.51	13.68	NA	XXX
71551	26	A	Mri chest w/dye	1.73	0.57	0.57	0.08	2.38	2.38	XXX
71551	TC	A	Mri chest w/dye	0.00	13.48	NA	0.52	14.00	NA	XXX
71551	.....	A	Mri chest w/dye	1.73	14.05	NA	0.60	16.38	NA	XXX
71552	26	A	Mri chest w/o & w/dye	2.26	0.74	0.74	0.10	3.10	3.10	XXX
71552	TC	A	Mri chest w/o & w/dye	0.00	24.95	NA	0.68	25.63	NA	XXX
71552	.....	A	Mri chest w/o & w/dye	2.26	25.69	NA	0.78	28.73	NA	XXX
71555	26	R	Mri angio chest w or w/o dye	1.81	0.60	0.60	0.08	2.49	2.49	XXX
71555	TC	R	Mri angio chest w or w/o dye	0.00	11.23	NA	0.59	11.82	NA	XXX
71555	.....	R	Mri angio chest w or w/o dye	1.81	11.83	NA	0.67	14.31	NA	XXX
72010	26	A	X-ray exam of spine	0.45	0.15	0.15	0.02	0.62	0.62	XXX
72010	TC	A	X-ray exam of spine	0.00	1.02	NA	0.06	1.08	NA	XXX
72010	.....	A	X-ray exam of spine	0.45	1.17	NA	0.08	1.70	NA	XXX
72020	26	A	X-ray exam of spine	0.15	0.05	0.05	0.01	0.21	0.21	XXX
72020	TC	A	X-ray exam of spine	0.00	0.42	NA	0.02	0.44	NA	XXX
72020	.....	A	X-ray exam of spine	0.15	0.47	NA	0.03	0.65	NA	XXX
72040	26	A	X-ray exam of neck spine	0.22	0.07	0.07	0.01	0.30	0.30	XXX
72040	TC	A	X-ray exam of neck spine	0.00	0.60	NA	0.04	0.64	NA	XXX
72040	.....	A	X-ray exam of neck spine	0.22	0.67	NA	0.05	0.94	NA	XXX
72050	26	A	X-ray exam of neck spine	0.31	0.10	0.10	0.01	0.42	0.42	XXX
72050	TC	A	X-ray exam of neck spine	0.00	0.89	NA	0.06	0.95	NA	XXX
72050	.....	A	X-ray exam of neck spine	0.31	0.99	NA	0.07	1.37	NA	XXX
72052	26	A	X-ray exam of neck spine	0.36	0.12	0.12	0.02	0.50	0.50	XXX
72052	TC	A	X-ray exam of neck spine	0.00	1.13	NA	0.06	1.19	NA	XXX
72052	.....	A	X-ray exam of neck spine	0.36	1.25	NA	0.08	1.69	NA	XXX
72069	26	A	X-ray exam of trunk spine	0.22	0.08	0.08	0.01	0.31	0.31	XXX
72069	TC	A	X-ray exam of trunk spine	0.00	0.49	NA	0.02	0.51	NA	XXX
72069	.....	A	X-ray exam of trunk spine	0.22	0.57	NA	0.03	0.82	NA	XXX
72070	26	A	X-ray exam of thoracic spine	0.22	0.07	0.07	0.01	0.30	0.30	XXX
72070	TC	A	X-ray exam of thoracic spine	0.00	0.65	NA	0.04	0.69	NA	XXX
72070	.....	A	X-ray exam of thoracic spine	0.22	0.72	NA	0.05	0.99	NA	XXX
72072	26	A	X-ray exam of thoracic spine	0.22	0.07	0.07	0.01	0.30	0.30	XXX
72072	TC	A	X-ray exam of thoracic spine	0.00	0.73	NA	0.05	0.78	NA	XXX
72072	.....	A	X-ray exam of thoracic spine	0.22	0.80	NA	0.06	1.08	NA	XXX
72074	26	A	X-ray exam of thoracic spine	0.22	0.07	0.07	0.01	0.30	0.30	XXX
72074	TC	A	X-ray exam of thoracic spine	0.00	0.91	NA	0.06	0.97	NA	XXX
72074	.....	A	X-ray exam of thoracic spine	0.22	0.98	NA	0.07	1.27	NA	XXX
72080	26	A	X-ray exam of trunk spine	0.22	0.07	0.07	0.01	0.30	0.30	XXX
72080	TC	A	X-ray exam of trunk spine	0.00	0.67	NA	0.04	0.71	NA	XXX
72080	.....	A	X-ray exam of trunk spine	0.22	0.74	NA	0.05	1.01	NA	XXX
72090	26	A	X-ray exam of trunk spine	0.28	0.09	0.09	0.01	0.38	0.38	XXX
72090	TC	A	X-ray exam of trunk spine	0.00	0.67	NA	0.04	0.71	NA	XXX
72090	.....	A	X-ray exam of trunk spine	0.28	0.76	NA	0.05	1.09	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
72100	26	A	X-ray exam of lower spine	0.22	0.07	0.07	0.01	0.30	0.30	XXX
72100	TC	A	X-ray exam of lower spine	0.00	0.67	NA	0.04	0.71	NA	XXX
72100	.....	A	X-ray exam of lower spine	0.22	0.74	NA	0.05	1.01	NA	XXX
72110	26	A	X-ray exam of lower spine	0.31	0.10	0.10	0.01	0.42	0.42	XXX
72110	TC	A	X-ray exam of lower spine	0.00	0.91	NA	0.06	0.97	NA	XXX
72110	.....	A	X-ray exam of lower spine	0.31	1.01	NA	0.07	1.39	NA	XXX
72114	26	A	X-ray exam of lower spine	0.36	0.12	0.12	0.02	0.50	0.50	XXX
72114	TC	A	X-ray exam of lower spine	0.00	1.19	NA	0.06	1.25	NA	XXX
72114	.....	A	X-ray exam of lower spine	0.36	1.31	NA	0.08	1.75	NA	XXX
72120	26	A	X-ray exam of lower spine	0.22	0.07	0.07	0.01	0.30	0.30	XXX
72120	TC	A	X-ray exam of lower spine	0.00	0.89	NA	0.06	0.95	NA	XXX
72120	.....	A	X-ray exam of lower spine	0.22	0.96	NA	0.07	1.25	NA	XXX
72125	26	A	Ct neck spine w/o dye	1.16	0.38	0.38	0.05	1.59	1.59	XXX
72125	TC	A	Ct neck spine w/o dye	0.00	5.93	NA	0.31	6.24	NA	XXX
72125	.....	A	Ct neck spine w/o dye	1.16	6.31	NA	0.36	7.83	NA	XXX
72126	26	A	Ct neck spine w/dye	1.22	0.40	0.40	0.05	1.67	1.67	XXX
72126	TC	A	Ct neck spine w/dye	0.00	7.09	NA	0.37	7.46	NA	XXX
72126	.....	A	Ct neck spine w/dye	1.22	7.49	NA	0.42	9.13	NA	XXX
72127	26	A	Ct neck spine w/o & w/dye	1.27	0.42	0.42	0.06	1.75	1.75	XXX
72127	TC	A	Ct neck spine w/o & w/dye	0.00	8.88	NA	0.46	9.34	NA	XXX
72127	.....	A	Ct neck spine w/o & w/dye	1.27	9.30	NA	0.52	11.09	NA	XXX
72128	26	A	Ct chest spine w/o dye	1.16	0.38	0.38	0.05	1.59	1.59	XXX
72128	TC	A	Ct chest spine w/o dye	0.00	5.93	NA	0.31	6.24	NA	XXX
72128	.....	A	Ct chest spine w/o dye	1.16	6.31	NA	0.36	7.83	NA	XXX
72129	26	A	Ct chest spine w/dye	1.22	0.40	0.40	0.05	1.67	1.67	XXX
72129	TC	A	Ct chest spine w/dye	0.00	7.09	NA	0.37	7.46	NA	XXX
72129	.....	A	Ct chest spine w/dye	1.22	7.49	NA	0.42	9.13	NA	XXX
72130	26	A	Ct chest spine w/o & w/dye	1.27	0.42	0.42	0.06	1.75	1.75	XXX
72130	TC	A	Ct chest spine w/o & w/dye	0.00	8.88	NA	0.46	9.34	NA	XXX
72130	.....	A	Ct chest spine w/o & w/dye	1.27	9.30	NA	0.52	11.09	NA	XXX
72131	26	A	Ct lumbar spine w/o dye	1.16	0.38	0.38	0.05	1.59	1.59	XXX
72131	TC	A	Ct lumbar spine w/o dye	0.00	5.93	NA	0.31	6.24	NA	XXX
72131	.....	A	Ct lumbar spine w/o dye	1.16	6.31	NA	0.36	7.83	NA	XXX
72132	26	A	Ct lumbar spine w/dye	1.22	0.40	0.40	0.05	1.67	1.67	XXX
72132	TC	A	Ct lumbar spine w/dye	0.00	7.09	NA	0.37	7.46	NA	XXX
72132	.....	A	Ct lumbar spine w/dye	1.22	7.49	NA	0.42	9.13	NA	XXX
72133	26	A	Ct lumbar spine w/o & w/dye	1.27	0.42	0.42	0.06	1.75	1.75	XXX
72133	TC	A	Ct lumbar spine w/o & w/dye	0.00	8.88	NA	0.46	9.34	NA	XXX
72133	.....	A	Ct lumbar spine w/o & w/dye	1.27	9.30	NA	0.52	11.09	NA	XXX
72141	26	A	Mri neck spine w/o dye	1.60	0.53	0.53	0.07	2.20	2.20	XXX
72141	TC	A	Mri neck spine w/o dye	0.00	11.23	NA	0.59	11.82	NA	XXX
72141	.....	A	Mri neck spine w/o dye	1.60	11.76	NA	0.66	14.02	NA	XXX
72142	26	A	Mri neck spine w/dye	1.92	0.64	0.64	0.09	2.65	2.65	XXX
72142	TC	A	Mri neck spine w/dye	0.00	13.48	NA	0.70	14.18	NA	XXX
72142	.....	A	Mri neck spine w/dye	1.92	14.12	NA	0.79	16.83	NA	XXX
72146	26	A	Mri chest spine w/o dye	1.60	0.53	0.53	0.07	2.20	2.20	XXX
72146	TC	A	Mri chest spine w/o dye	0.00	12.48	NA	0.64	13.12	NA	XXX
72146	.....	A	Mri chest spine w/o dye	1.60	13.01	NA	0.71	15.32	NA	XXX
72147	26	A	Mri chest spine w/dye	1.92	0.63	0.63	0.09	2.64	2.64	XXX
72147	TC	A	Mri chest spine w/dye	0.00	13.48	NA	0.70	14.18	NA	XXX
72147	.....	A	Mri chest spine w/dye	1.92	14.11	NA	0.79	16.82	NA	XXX
72148	26	A	Mri lumbar spine w/o dye	1.48	0.49	0.49	0.07	2.04	2.04	XXX
72148	TC	A	Mri lumbar spine w/o dye	0.00	12.48	NA	0.64	13.12	NA	XXX
72148	.....	A	Mri lumbar spine w/o dye	1.48	12.97	NA	0.71	15.16	NA	XXX
72149	26	A	Mri lumbar spine w/dye	1.78	0.60	0.60	0.08	2.46	2.46	XXX
72149	TC	A	Mri lumbar spine w/dye	0.00	13.48	NA	0.70	14.18	NA	XXX
72149	.....	A	Mri lumbar spine w/dye	1.78	14.08	NA	0.78	16.64	NA	XXX
72156	26	A	Mri neck spine w/o & w/dye	2.57	0.85	0.85	0.11	3.53	3.53	XXX
72156	TC	A	Mri neck spine w/o & w/dye	0.00	24.95	NA	1.31	26.26	NA	XXX
72156	.....	A	Mri neck spine w/o & w/dye	2.57	25.80	NA	1.42	29.79	NA	XXX
72157	26	A	Mri chest spine w/o & w/dye	2.57	0.84	0.84	0.11	3.52	3.52	XXX
72157	TC	A	Mri chest spine w/o & w/dye	0.00	24.95	NA	1.31	26.26	NA	XXX
72157	.....	A	Mri chest spine w/o & w/dye	2.57	25.79	NA	1.42	29.78	NA	XXX
72158	26	A	Mri lumbar spine w/o & w/dye	2.36	0.78	0.78	0.10	3.24	3.24	XXX
72158	TC	A	Mri lumbar spine w/o & w/dye	0.00	24.95	NA	1.31	26.26	NA	XXX
72158	.....	A	Mri lumbar spine w/o & w/dye	2.36	25.73	NA	1.41	29.50	NA	XXX
72159	26	N	Mr angio spine w/o&w/dye	+1.80	0.69	0.69	0.10	2.59	2.59	XXX
72159	TC	N	Mr angio spine w/o&w/dye	+0.00	12.27	12.27	0.64	12.91	12.91	XXX
72159	.....	N	Mr angio spine w/o&w/dye	+1.80	12.96	12.96	0.74	15.50	15.50	XXX
72170	26	A	X-ray exam of pelvis	0.17	0.06	0.06	0.01	0.24	0.24	XXX
72170	TC	A	X-ray exam of pelvis	0.00	0.52	NA	0.02	0.54	NA	XXX
72170	.....	A	X-ray exam of pelvis	0.17	0.58	NA	0.03	0.78	NA	XXX
72190	26	A	X-ray exam of pelvis	0.21	0.07	0.07	0.01	0.29	0.29	XXX
72190	TC	A	X-ray exam of pelvis	0.00	0.67	NA	0.04	0.71	NA	XXX
72190	.....	A	X-ray exam of pelvis	0.21	0.74	NA	0.05	1.00	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
72191	26	A	Ct angiograph pelv w/o&w/dye	1.81	0.60	0.60	0.08	2.49	2.49	XXX
72191	TC	A	Ct angiograph pelv w/o&w/dye	0.00	12.06	NA	0.39	12.45	NA	XXX
72191	.....	A	Ct angiograph pelv w/o&w/dye	1.81	12.66	NA	0.47	14.94	NA	XXX
72192	26	A	Ct pelvis w/o dye	1.09	0.36	0.36	0.05	1.50	1.50	XXX
72192	TC	A	Ct pelvis w/o dye	0.00	5.93	NA	0.31	6.24	NA	XXX
72192	.....	A	Ct pelvis w/o dye	1.09	6.29	NA	0.36	7.74	NA	XXX
72193	26	A	Ct pelvis w/dye	1.16	0.38	0.38	0.05	1.59	1.59	XXX
72193	TC	A	Ct pelvis w/dye	0.00	6.86	NA	0.36	7.22	NA	XXX
72193	.....	A	Ct pelvis w/dye	1.16	7.24	NA	0.41	8.81	NA	XXX
72194	26	A	Ct pelvis w/o & w/dye	1.22	0.40	0.40	0.05	1.67	1.67	XXX
72194	TC	A	Ct pelvis w/o & w/dye	0.00	8.51	NA	0.43	8.94	NA	XXX
72194	.....	A	Ct pelvis w/o & w/dye	1.22	8.91	NA	0.48	10.61	NA	XXX
72195	26	A	Mri pelvis w/o dye	1.46	0.48	0.48	0.06	2.00	2.00	XXX
72195	TC	A	Mri pelvis w/o dye	0.00	11.23	NA	0.45	11.68	NA	XXX
72195	.....	A	Mri pelvis w/o dye	1.46	11.71	NA	0.51	13.68	NA	XXX
72196	26	A	Mri pelvis w/dye	1.73	0.57	0.57	0.08	2.38	2.38	XXX
72196	TC	A	Mri pelvis w/dye	0.00	13.48	NA	0.52	14.00	NA	XXX
72196	.....	A	Mri pelvis w/dye	1.73	14.05	NA	0.60	16.38	NA	XXX
72197	26	A	Mri pelvis w/o & w/dye	2.26	0.74	0.74	0.10	3.10	3.10	XXX
72197	TC	A	Mri pelvis w/o & w/dye	0.00	24.95	NA	0.92	25.87	NA	XXX
72197	.....	A	Mri pelvis w/o & w/dye	2.26	25.69	NA	1.02	28.97	NA	XXX
72198	26	A	Mr angio pelvis w/o & w/dye	1.80	0.59	0.59	0.08	2.47	2.47	XXX
72198	TC	A	Mr angio pelvis w/o & w/dye	0.00	11.23	NA	0.59	11.82	NA	XXX
72198	.....	A	Mr angio pelvis w/o & w/dye	1.80	11.82	NA	0.67	14.29	NA	XXX
72200	26	A	X-ray exam sacroiliac joints	0.17	0.06	0.06	0.01	0.24	0.24	XXX
72200	TC	A	X-ray exam sacroiliac joints	0.00	0.52	NA	0.02	0.54	NA	XXX
72200	.....	A	X-ray exam sacroiliac joints	0.17	0.58	NA	0.03	0.78	NA	XXX
72202	26	A	X-ray exam sacroiliac joints	0.19	0.06	0.06	0.01	0.26	0.26	XXX
72202	TC	A	X-ray exam sacroiliac joints	0.00	0.62	NA	0.04	0.66	NA	XXX
72202	.....	A	X-ray exam sacroiliac joints	0.19	0.68	NA	0.05	0.92	NA	XXX
72220	26	A	X-ray exam of tailbone	0.17	0.06	0.06	0.01	0.24	0.24	XXX
72220	TC	A	X-ray exam of tailbone	0.00	0.57	NA	0.04	0.61	NA	XXX
72220	.....	A	X-ray exam of tailbone	0.17	0.63	NA	0.05	0.85	NA	XXX
72240	26	A	Contrast x-ray of neck spine	0.91	0.29	0.29	0.04	1.24	1.24	XXX
72240	TC	A	Contrast x-ray of neck spine	0.00	4.76	NA	0.25	5.01	NA	XXX
72240	.....	A	Contrast x-ray of neck spine	0.91	5.05	NA	0.29	6.25	NA	XXX
72255	26	A	Contrast x-ray, thorax spine	0.91	0.27	0.27	0.04	1.22	1.22	XXX
72255	TC	A	Contrast x-ray, thorax spine	0.00	4.34	NA	0.22	4.56	NA	XXX
72255	.....	A	Contrast x-ray, thorax spine	0.91	4.61	NA	0.26	5.78	NA	XXX
72265	26	A	Contrast x-ray, lower spine	0.83	0.25	0.25	0.04	1.12	1.12	XXX
72265	C	A	Contrast x-ray, lower spine	0.00	4.08	NA	0.22	4.30	NA	XXX
72265	.....	A	Contrast x-ray, lower spine	0.83	4.33	NA	0.26	5.42	NA	XXX
72270	26	A	Contrast x-ray, spine	1.33	0.42	0.42	0.06	1.81	1.81	XXX
72270	TC	A	Contrast x-ray, spine	0.00	6.12	NA	0.33	6.45	NA	XXX
72270	.....	A	Contrast x-ray, spine	1.33	6.54	NA	0.39	8.26	NA	XXX
72275	26	A	Epidurography	0.76	0.20	0.20	0.04	1.00	1.00	XXX
72275	TC	A	Epidurography	0.00	2.11	NA	0.22	2.33	NA	XXX
72275	.....	A	Epidurography	0.76	2.31	NA	0.26	3.33	NA	XXX
72285	26	A	X-ray c/t spine disk	1.16	0.36	0.36	0.07	1.59	1.59	XXX
72285	TC	A	X-ray c/t spine disk	0.00	8.40	NA	0.43	8.83	NA	XXX
72285	.....	A	X-ray c/t spine disk	1.16	8.76	NA	0.50	10.42	NA	XXX
72295	26	A	X-ray of lower spine disk	0.83	0.27	0.27	0.06	1.16	1.16	XXX
72295	TC	A	X-ray of lower spine disk	0.00	7.88	NA	0.40	8.28	NA	XXX
72295	.....	A	X-ray of lower spine disk	0.83	8.15	NA	0.46	9.44	NA	XXX
73000	26	A	X-ray exam of collar bone	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73000	TC	A	X-ray exam of collar bone	0.00	0.52	NA	0.02	0.54	NA	XXX
73000	.....	A	X-ray exam of collar bone	0.16	0.57	NA	0.03	0.76	NA	XXX
73010	26	A	X-ray exam of shoulder blade	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73010	TC	A	X-ray exam of shoulder blade	0.00	0.52	NA	0.02	0.54	NA	XXX
73010	.....	A	X-ray exam of shoulder blade	0.17	0.58	NA	0.03	0.78	NA	XXX
73020	26	A	X-ray exam of shoulder	0.15	0.05	0.05	0.01	0.21	0.21	XXX
73020	TC	A	X-ray exam of shoulder	0.00	0.47	NA	0.02	0.49	NA	XXX
73020	.....	A	X-ray exam of shoulder	0.15	0.52	NA	0.03	0.70	NA	XXX
73030	26	A	X-ray exam of shoulder	0.18	0.06	0.06	0.01	0.25	0.25	XXX
73030	TC	A	X-ray exam of shoulder	0.00	0.57	NA	0.04	0.61	NA	XXX
73030	.....	A	X-ray exam of shoulder	0.18	0.63	NA	0.05	0.86	NA	XXX
73040	26	A	Contrast x-ray of shoulder	0.54	0.18	0.18	0.02	0.74	0.74	XXX
73040	TC	A	Contrast x-ray of shoulder	0.00	2.11	NA	0.12	2.23	NA	XXX
73040	.....	A	Contrast x-ray of shoulder	0.54	2.29	NA	0.14	2.97	NA	XXX
73050	26	A	X-ray exam of shoulders	0.20	0.07	0.07	0.01	0.28	0.28	XXX
73050	TC	A	X-ray exam of shoulders	0.00	0.67	NA	0.04	0.71	NA	XXX
73050	.....	A	X-ray exam of shoulders	0.20	0.74	NA	0.05	0.99	NA	XXX
73060	26	A	X-ray exam of humerus	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73060	TC	A	X-ray exam of humerus	0.00	0.57	NA	0.04	0.61	NA	XXX
73060	.....	A	X-ray exam of humerus	0.17	0.63	NA	0.05	0.85	NA	XXX

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[3] +Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
73070	26	A	X-ray exam of elbow	0.15	0.05	0.05	0.01	0.21	0.21	XXX
73070	TC	A	X-ray exam of elbow	0.00	0.52	NA	0.02	0.54	NA	XXX
73070	.....	A	X-ray exam of elbow	0.15	0.57	NA	0.03	0.75	NA	XXX
73080	26	A	X-ray exam of elbow	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73080	TC	A	X-ray exam of elbow	0.00	0.57	NA	0.04	0.61	NA	XXX
73080	.....	A	X-ray exam of elbow	0.17	0.63	NA	0.05	0.85	NA	XXX
73085	26	A	Contrast x-ray of elbow	0.54	0.19	0.19	0.02	0.75	0.75	XXX
73085	TC	A	Contrast x-ray of elbow	0.00	2.11	NA	0.12	2.23	NA	XXX
73085	.....	A	Contrast x-ray of elbow	0.54	2.30	NA	0.14	2.98	NA	XXX
73090	26	A	X-ray exam of forearm	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73090	TC	A	X-ray exam of forearm	0.00	0.52	NA	0.02	0.54	NA	XXX
73090	.....	A	X-ray exam of forearm	0.16	0.57	NA	0.03	0.76	NA	XXX
73092	26	A	X-ray exam of arm, infant	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73092	TC	A	X-ray exam of arm, infant	0.00	0.49	NA	0.02	0.51	NA	XXX
73092	.....	A	X-ray exam of arm, infant	0.16	0.54	NA	0.03	0.73	NA	XXX
73100	26	A	X-ray exam of wrist	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73100	TC	A	X-ray exam of wrist	0.00	0.49	NA	0.02	0.51	NA	XXX
73100	.....	A	X-ray exam of wrist	0.16	0.54	NA	0.03	0.73	NA	XXX
73110	26	A	X-ray exam of wrist	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73110	TC	A	X-ray exam of wrist	0.00	0.53	NA	0.02	0.55	NA	XXX
73110	.....	A	X-ray exam of wrist	0.17	0.59	NA	0.03	0.79	NA	XXX
73115	26	A	Contrast x-ray of wrist	0.54	0.18	0.18	0.02	0.74	0.74	XXX
73115	TC	A	Contrast x-ray of wrist	0.00	1.58	NA	0.10	1.68	NA	XXX
73115	.....	A	Contrast x-ray of wrist	0.54	1.76	NA	0.12	2.42	NA	XXX
73120	26	A	X-ray exam of hand	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73120	TC	A	X-ray exam of hand	0.00	0.49	NA	0.02	0.51	NA	XXX
73120	.....	A	X-ray exam of hand	0.16	0.54	NA	0.03	0.73	NA	XXX
73130	26	A	X-ray exam of hand	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73130	TC	A	X-ray exam of hand	0.00	0.53	NA	0.02	0.55	NA	XXX
73130	.....	A	X-ray exam of hand	0.17	0.59	NA	0.03	0.79	NA	XXX
73140	26	A	X-ray exam of finger(s)	0.13	0.04	0.04	0.01	0.18	0.18	XXX
73140	TC	A	X-ray exam of finger(s)	0.00	0.42	NA	0.02	0.44	NA	XXX
73140	.....	A	X-ray exam of finger(s)	0.13	0.46	NA	0.03	0.62	NA	XXX
73200	26	A	Ct upper extremity w/o dye	1.09	0.36	0.36	0.05	1.50	1.50	XXX
73200	TC	A	Ct upper extremity w/o dye	0.00	4.97	NA	0.25	5.22	NA	XXX
73200	.....	A	Ct upper extremity w/o dye	1.09	5.33	NA	0.30	6.72	NA	XXX
73201	26	A	Ct upper extremity w/dye	1.16	0.38	0.38	0.05	1.59	1.59	XXX
73201	TC	A	Ct upper extremity w/dye	0.00	5.93	NA	0.31	6.24	NA	XXX
73201	.....	A	Ct upper extremity w/dye	1.16	6.31	NA	0.36	7.83	NA	XXX
73202	26	A	Ct uppr extremity w/o&w/dye	1.22	0.40	0.40	0.05	1.67	1.67	XXX
73202	TC	A	Ct uppr extremity w/o&w/dye	0.00	7.44	NA	0.39	7.83	NA	XXX
73202	.....	A	Ct uppr extremity w/o&w/dye	1.22	7.84	NA	0.44	9.50	NA	XXX
73206	26	A	Ct angio upr extrm w/o&w/dye	1.81	0.59	0.59	0.08	2.48	2.48	XXX
73206	TC	A	Ct angio upr extrm w/o&w/dye	0.00	10.99	NA	0.39	11.38	NA	XXX
73206	.....	A	Ct angio upr extrm w/o&w/dye	1.81	11.58	NA	0.47	13.86	NA	XXX
73218	26	A	Mri upper extremity w/o dye	1.35	0.44	0.44	0.06	1.85	1.85	XXX
73218	TC	A	Mri upper extremity w/o dye	0.00	11.23	NA	0.39	11.62	NA	XXX
73218	.....	A	Mri upper extremity w/o dye	1.35	11.67	NA	0.45	13.47	NA	XXX
73219	26	A	Mri upper extremity w/dye	1.62	0.54	0.54	0.07	2.23	2.23	XXX
73219	TC	A	Mri upper extremity w/dye	0.00	13.48	NA	0.47	13.95	NA	XXX
73219	.....	A	Mri upper extremity w/dye	1.62	14.02	NA	0.54	16.18	NA	XXX
73220	26	A	Mri uppr extremity w/o&w/dye	2.15	0.71	0.71	0.10	2.96	2.96	XXX
73220	TC	A	Mri uppr extremity w/o&w/dye	0.00	24.95	NA	0.84	25.79	NA	XXX
73220	.....	A	Mri uppr extremity w/o&w/dye	2.15	25.66	NA	0.94	28.75	NA	XXX
73221	26	A	Mri joint upr extrem w/o dye	1.35	0.44	0.44	0.06	1.85	1.85	XXX
73221	TC	A	Mri joint upr extrem w/o dye	0.00	11.23	NA	0.39	11.62	NA	XXX
73221	.....	A	Mri joint upr extrem w/o dye	1.35	11.67	NA	0.45	13.47	NA	XXX
73222	26	A	Mri joint upr extrem w/dye	1.62	0.53	0.53	0.07	2.22	2.22	XXX
73222	TC	A	Mri joint upr extrem w/dye	0.00	13.48	NA	0.47	13.95	NA	XXX
73222	.....	A	Mri joint upr extrem w/dye	1.62	14.01	NA	0.54	16.17	NA	XXX
73223	26	A	Mri joint upr extr w/o&w/dye	2.15	0.71	0.71	0.10	2.96	2.96	XXX
73223	TC	A	Mri joint upr extr w/o&w/dye	0.00	24.95	NA	0.84	25.79	NA	XXX
73223	.....	A	Mri joint upr extr w/o&w/dye	2.15	25.66	NA	0.94	28.75	NA	XXX
73225	26	N	Mr angio upr extr w/o&w/dye	+1.73	0.67	0.67	0.10	2.50	2.50	XXX
73225	TC	N	Mr angio upr extr w/o&w/dye	+0.00	11.04	11.04	0.59	11.63	11.63	XXX
73225	.....	N	Mr angio upr extr w/o&w/dye	+1.73	11.71	11.71	0.69	14.13	14.13	XXX
73500	26	A	X-ray exam of hip	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73500	TC	A	X-ray exam of hip	0.00	0.47	NA	0.02	0.49	NA	XXX
73500	.....	A	X-ray exam of hip	0.17	0.53	NA	0.03	0.73	NA	XXX
73510	26	A	X-ray exam of hip	0.21	0.07	0.07	0.01	0.29	0.29	XXX
73510	TC	A	X-ray exam of hip	0.00	0.57	NA	0.04	0.61	NA	XXX
73510	.....	A	X-ray exam of hip	0.21	0.64	NA	0.05	0.90	NA	XXX
73520	26	A	X-ray exam of hips	0.26	0.09	0.09	0.01	0.36	0.36	XXX
73520	TC	A	X-ray exam of hips	0.00	0.67	NA	0.04	0.71	NA	XXX
73520	.....	A	X-ray exam of hips	0.26	0.76	NA	0.05	1.07	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
73525	26	A	Contrast x-ray of hip	0.54	0.18	0.18	0.03	0.75	0.75	XXX
73525	TC	A	Contrast x-ray of hip	0.00	2.11	NA	0.12	2.23	NA	XXX
73525	.....	A	Contrast x-ray of hip	0.54	2.29	NA	0.15	2.98	NA	XXX
73530	26	A	X-ray exam of hip	0.29	0.10	0.10	0.01	0.40	0.40	XXX
73530	TC	A	X-ray exam of hip	0.00	0.52	NA	0.02	0.54	NA	XXX
73530	.....	A	X-ray exam of hip	0.29	0.62	NA	0.03	0.94	NA	XXX
73540	26	A	X-ray exam of pelvis & hips	0.20	0.07	0.07	0.01	0.28	0.28	XXX
73540	TC	A	X-ray exam of pelvis & hips	0.00	0.57	NA	0.04	0.61	NA	XXX
73540	.....	A	X-ray exam of pelvis & hips	0.20	0.64	NA	0.05	0.89	NA	XXX
73542	26	A	X-ray exam, sacroiliac joint	0.59	0.16	0.16	0.03	0.78	0.78	XXX
73542	TC	A	X-ray exam, sacroiliac joint	0.00	2.11	NA	0.12	2.23	NA	XXX
73542	.....	A	X-ray exam, sacroiliac joint	0.59	2.27	NA	0.15	3.01	NA	XXX
73550	26	A	X-ray exam of thigh	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73550	TC	A	X-ray exam of thigh	0.00	0.57	NA	0.04	0.61	NA	XXX
73550	.....	A	X-ray exam of thigh	0.17	0.63	NA	0.05	0.85	NA	XXX
73560	26	A	X-ray exam of knee, 1 or 2	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73560	TC	A	X-ray exam of knee, 1 or 2	0.00	0.52	NA	0.02	0.54	NA	XXX
73560	.....	A	X-ray exam of knee, 1 or 2	0.17	0.58	NA	0.03	0.78	NA	XXX
73562	26	A	X-ray exam of knee, 3	0.18	0.06	0.06	0.01	0.25	0.25	XXX
73562	TC	A	X-ray exam of knee, 3	0.00	0.57	NA	0.04	0.61	NA	XXX
73562	.....	A	X-ray exam of knee, 3	0.18	0.63	NA	0.05	0.86	NA	XXX
73564	26	A	X-ray exam, knee, 4 or more	0.22	0.07	0.07	0.01	0.30	0.30	XXX
73564	TC	A	X-ray exam, knee, 4 or more	0.00	0.62	NA	0.04	0.66	NA	XXX
73564	.....	A	X-ray exam, knee, 4 or more	0.22	0.69	NA	0.05	0.96	NA	XXX
73565	26	A	X-ray exam of knees	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73565	TC	A	X-ray exam of knees	0.00	0.49	NA	0.02	0.51	NA	XXX
73565	.....	A	X-ray exam of knees	0.17	0.55	NA	0.03	0.75	NA	XXX
73580	26	A	Contrast x-ray of knee joint	0.54	0.17	0.17	0.03	0.74	0.74	XXX
73580	TC	A	Contrast x-ray of knee joint	0.00	2.63	NA	0.14	2.77	NA	XXX
73580	.....	A	Contrast x-ray of knee joint	0.54	2.80	NA	0.17	3.51	NA	XXX
73590	26	A	X-ray exam of lower leg	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73590	TC	A	X-ray exam of lower leg	0.00	0.52	NA	0.02	0.54	NA	XXX
73590	.....	A	X-ray exam of lower leg	0.17	0.58	NA	0.03	0.78	NA	XXX
73592	26	A	X-ray exam of leg, infant	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73592	TC	A	X-ray exam of leg, infant	0.00	0.49	NA	0.02	0.51	NA	XXX
73592	.....	A	X-ray exam of leg, infant	0.16	0.54	NA	0.03	0.73	NA	XXX
73600	26	A	X-ray exam of ankle	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73600	TC	A	X-ray exam of ankle	0.00	0.49	NA	0.02	0.51	NA	XXX
73600	.....	A	X-ray exam of ankle	0.16	0.54	NA	0.03	0.73	NA	XXX
73610	26	A	X-ray exam of ankle	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73610	TC	A	X-ray exam of ankle	0.00	0.53	NA	0.02	0.55	NA	XXX
73610	.....	A	X-ray exam of ankle	0.17	0.59	NA	0.03	0.79	NA	XXX
73615	26	A	Contrast x-ray of ankle	0.54	0.18	0.18	0.03	0.75	0.75	XXX
73615	TC	A	Contrast x-ray of ankle	0.00	2.11	NA	0.12	2.23	NA	XXX
73615	.....	A	Contrast x-ray of ankle	0.54	2.29	NA	0.15	2.98	NA	XXX
73620	26	A	X-ray exam of foot	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73620	TC	A	X-ray exam of foot	0.00	0.49	NA	0.02	0.51	NA	XXX
73620	.....	A	X-ray exam of foot	0.16	0.54	NA	0.03	0.73	NA	XXX
73630	26	A	X-ray exam of foot	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73630	TC	A	X-ray exam of foot	0.00	0.53	NA	0.02	0.55	NA	XXX
73630	.....	A	X-ray exam of foot	0.17	0.59	NA	0.03	0.79	NA	XXX
73650	26	A	X-ray exam of heel	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73650	TC	A	X-ray exam of heel	0.00	0.47	NA	0.02	0.49	NA	XXX
73650	.....	A	X-ray exam of heel	0.16	0.52	NA	0.03	0.71	NA	XXX
73660	26	A	X-ray exam of toe(s)	0.13	0.04	0.04	0.01	0.18	0.18	XXX
73660	TC	A	X-ray exam of toe(s)	0.00	0.42	NA	0.02	0.44	NA	XXX
73660	.....	A	X-ray exam of toe(s)	0.13	0.46	NA	0.03	0.62	NA	XXX
73700	26	A	Ct lower extremity w/o dye	1.09	0.36	0.36	0.05	1.50	1.50	XXX
73700	TC	A	Ct lower extremity w/o dye	0.00	4.97	NA	0.25	5.22	NA	XXX
73700	.....	A	Ct lower extremity w/o dye	1.09	5.33	NA	0.30	6.72	NA	XXX
73701	26	A	Ct lower extremity w/dye	1.16	0.38	0.38	0.05	1.59	1.59	XXX
73701	TC	A	Ct lower extremity w/dye	0.00	5.93	NA	0.31	6.24	NA	XXX
73701	.....	A	Ct lower extremity w/dye	1.16	6.31	NA	0.36	7.83	NA	XXX
73702	26	A	Ct lwr extremity w/o&w/dye	1.22	0.40	0.40	0.05	1.67	1.67	XXX
73702	TC	A	Ct lwr extremity w/o&w/dye	0.00	7.44	NA	0.39	7.83	NA	XXX
73702	.....	A	Ct lwr extremity w/o&w/dye	1.22	7.84	NA	0.44	9.50	NA	XXX
73706	26	A	Ct angio lwr extr w/o&w/dye	1.90	0.62	0.62	0.08	2.60	2.60	XXX
73706	TC	A	Ct angio lwr extr w/o&w/dye	0.00	10.99	NA	0.39	11.38	NA	XXX
73706	.....	A	Ct angio lwr extr w/o&w/dye	1.90	11.61	NA	0.47	13.98	NA	XXX
73718	26	A	Mri lower extremity w/o dye	1.35	0.44	0.44	0.06	1.85	1.85	XXX
73718	TC	A	Mri lower extremity w/o dye	0.00	11.23	NA	0.39	11.62	NA	XXX
73718	.....	A	Mri lower extremity w/o dye	1.35	11.67	NA	0.45	13.47	NA	XXX
73719	26	A	Mri lower extremity w/dye	1.62	0.53	0.53	0.07	2.22	2.22	XXX
73719	TC	A	Mri lower extremity w/dye	0.00	13.48	NA	0.47	13.95	NA	XXX
73719	.....	A	Mri lower extremity w/dye	1.62	14.01	NA	0.54	16.17	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
73720	26	A	Mri lwr extremity w/o&w/dye	2.15	0.70	0.70	0.10	2.95	2.95	XXX
73720	TC	A	Mri lwr extremity w/o&w/dye	0.00	24.95	NA	0.84	25.79	NA	XXX
73720	.....	A	Mri lwr extremity w/o&w/dye	2.15	25.65	NA	0.94	28.74	NA	XXX
73721	26	A	Mri jnt of lwr extre w/o dye	1.35	0.44	0.44	0.06	1.85	1.85	XXX
73721	TC	A	Mri jnt of lwr extre w/o dye	0.00	11.23	NA	0.39	11.62	NA	XXX
73721	.....	A	Mri jnt of lwr extre w/o dye	1.35	11.67	NA	0.45	13.47	NA	XXX
73722	26	A	Mri joint of lwr extr w/dye	1.62	0.53	0.53	0.07	2.22	2.22	XXX
73722	TC	A	Mri joint of lwr extr w/dye	0.00	13.48	NA	0.47	13.95	NA	XXX
73722	.....	A	Mri joint of lwr extr w/dye	1.62	14.01	NA	0.54	16.17	NA	XXX
73723	26	A	Mri joint lwr extr w/o&w/dye	2.15	0.71	0.71	0.10	2.96	2.96	XXX
73723	TC	A	Mri joint lwr extr w/o&w/dye	0.00	24.95	NA	0.84	25.79	NA	XXX
73723	.....	A	Mri joint lwr extr w/o&w/dye	2.15	25.66	NA	0.94	28.75	NA	XXX
73725	26	R	Mr ang lwr ext w or w/o dye	1.82	0.60	0.60	0.08	2.50	2.50	XXX
73725	TC	R	Mr ang lwr ext w or w/o dye	0.00	11.23	NA	0.59	11.82	NA	XXX
73725	.....	R	Mr ang lwr ext w or w/o dye	1.82	11.83	NA	0.67	14.32	NA	XXX
74000	26	A	X-ray exam of abdomen	0.18	0.06	0.06	0.01	0.25	0.25	XXX
74000	TC	A	X-ray exam of abdomen	0.00	0.52	NA	0.02	0.54	NA	XXX
74000	.....	A	X-ray exam of abdomen	0.18	0.58	NA	0.03	0.79	NA	XXX
74010	26	A	X-ray exam of abdomen	0.23	0.08	0.08	0.01	0.32	0.32	XXX
74010	TC	A	X-ray exam of abdomen	0.00	0.57	NA	0.04	0.61	NA	XXX
74010	.....	A	X-ray exam of abdomen	0.23	0.65	NA	0.05	0.93	NA	XXX
74020	26	A	X-ray exam of abdomen	0.27	0.09	0.09	0.01	0.37	0.37	XXX
74020	TC	A	X-ray exam of abdomen	0.00	0.62	NA	0.04	0.66	NA	XXX
74020	.....	A	X-ray exam of abdomen	0.27	0.71	NA	0.05	1.03	NA	XXX
74022	26	A	X-ray exam series, abdomen	0.32	0.10	0.10	0.01	0.43	0.43	XXX
74022	TC	A	X-ray exam series, abdomen	0.00	0.73	NA	0.05	0.78	NA	XXX
74022	.....	A	X-ray exam series, abdomen	0.32	0.83	NA	0.06	1.21	NA	XXX
74150	26	A	Ct abdomen w/o dye	1.19	0.39	0.39	0.05	1.63	1.63	XXX
74150	TC	A	Ct abdomen w/o dye	0.00	5.68	NA	0.30	5.98	NA	XXX
74150	.....	A	Ct abdomen w/o dye	1.19	6.07	NA	0.35	7.61	NA	XXX
74160	26	A	Ct abdomen w/dye	1.27	0.42	0.42	0.06	1.75	1.75	XXX
74160	TC	A	Ct abdomen w/dye	0.00	6.86	NA	0.36	7.22	NA	XXX
74160	.....	A	Ct abdomen w/dye	1.27	7.28	NA	0.42	8.97	NA	XXX
74170	26	A	Ct abdomen w/o & w/dye	1.40	0.46	0.46	0.06	1.92	1.92	XXX
74170	TC	A	Ct abdomen w/o & w/dye	0.00	8.51	NA	0.43	8.94	NA	XXX
74170	.....	A	Ct abdomen w/o & w/dye	1.40	8.97	NA	0.49	10.86	NA	XXX
74175	26	A	Ct angio abdom w/o & w/dye	1.90	0.62	0.62	0.08	2.60	2.60	XXX
74175	TC	A	Ct angio abdom w/o & w/dye	0.00	12.06	NA	0.39	12.45	NA	XXX
74175	.....	A	Ct angio abdom w/o & w/dye	1.90	12.68	NA	0.47	15.05	NA	XXX
74181	26	A	Mri abdomen w/o dye	1.46	0.48	0.48	0.06	2.00	2.00	XXX
74181	TC	A	Mri abdomen w/o dye	0.00	11.23	NA	0.45	11.68	NA	XXX
74181	.....	A	Mri abdomen w/o dye	1.46	11.71	NA	0.51	13.68	NA	XXX
74182	26	A	Mri abdomen w/dye	1.73	0.57	0.57	0.08	2.38	2.38	XXX
74182	TC	A	Mri abdomen w/dye	0.00	13.48	NA	0.52	14.00	NA	XXX
74182	.....	A	Mri abdomen w/dye	1.73	14.05	NA	0.60	16.38	NA	XXX
74183	26	A	Mri abdomen w/o & w/dye	2.26	0.74	0.74	0.10	3.10	3.10	XXX
74183	TC	A	Mri abdomen w/o & w/dye	0.00	24.95	NA	0.92	25.87	NA	XXX
74183	.....	A	Mri abdomen w/o & w/dye	2.26	25.69	NA	1.02	28.97	NA	XXX
74185	26	R	Mri angio, abdom w orw/o dye	1.80	0.59	0.59	0.08	2.47	2.47	XXX
74185	TC	R	Mri angio, abdom w orw/o dye	0.00	11.23	NA	0.59	11.82	NA	XXX
74185	.....	R	Mri angio, abdom w orw/o dye	1.80	11.82	NA	0.67	14.29	NA	XXX
74190	26	A	X-ray exam of peritoneum	0.48	0.16	0.16	0.02	0.66	0.66	XXX
74190	TC	A	X-ray exam of peritoneum	0.00	1.31	NA	0.07	1.38	NA	XXX
74190	.....	A	X-ray exam of peritoneum	0.48	1.47	NA	0.09	2.04	NA	XXX
74210	26	A	Contrst x-ray exam of throat	0.36	0.12	0.12	0.02	0.50	0.50	XXX
74210	TC	A	Contrst x-ray exam of throat	0.00	1.19	NA	0.06	1.25	NA	XXX
74210	.....	A	Contrst x-ray exam of throat	0.36	1.31	NA	0.08	1.75	NA	XXX
74220	26	A	Contrast x-ray, esophagus	0.46	0.15	0.15	0.02	0.63	0.63	XXX
74220	TC	A	Contrast x-ray, esophagus	0.00	1.19	NA	0.06	1.25	NA	XXX
74220	.....	A	Contrast x-ray, esophagus	0.46	1.34	NA	0.08	1.88	NA	XXX
74230	26	A	Cine/vid x-ray, throat/esoph	0.53	0.17	0.17	0.02	0.72	0.72	XXX
74230	TC	A	Cine/vid x-ray, throat/esoph	0.00	1.31	NA	0.07	1.38	NA	XXX
74230	.....	A	Cine/vid x-ray, throat/esoph	0.53	1.48	NA	0.09	2.10	NA	XXX
74235	26	A	Remove esophagus obstruction	1.19	0.39	0.39	0.05	1.63	1.63	XXX
74235	TC	C	Remove esophagus obstruction	0.00	0.00	0.00	0.00	0.00	0.00	XXX
74235	.....	C	Remove esophagus obstruction	0.00	0.00	0.00	0.00	0.00	0.00	XXX
74240	26	A	X-ray exam, upper gi tract	0.69	0.23	0.23	0.03	0.95	0.95	XXX
74240	TC	A	X-ray exam, upper gi tract	0.00	1.46	NA	0.08	1.54	NA	XXX
74240	.....	A	X-ray exam, upper gi tract	0.69	1.69	NA	0.11	2.49	NA	XXX
74241	26	A	X-ray exam, upper gi tract	0.69	0.23	0.23	0.03	0.95	0.95	XXX
74241	TC	A	X-ray exam, upper gi tract	0.00	1.49	NA	0.08	1.57	NA	XXX
74241	.....	A	X-ray exam, upper gi tract	0.69	1.72	NA	0.11	2.52	NA	XXX
74245	26	A	X-ray exam, upper gi tract	0.91	0.30	0.30	0.04	1.25	1.25	XXX
74245	TC	A	X-ray exam, upper gi tract	0.00	2.39	NA	0.13	2.52	NA	XXX
74245	.....	A	X-ray exam, upper gi tract	0.91	2.69	NA	0.17	3.77	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
74246	26	A	Contrst x-ray uppr gi tract	0.69	0.23	0.23	0.03	0.95	0.95	XXX
74246	TC	A	Contrst x-ray uppr gi tract	0.00	1.64	NA	0.10	1.74	NA	XXX
74246	.....	A	Contrst x-ray uppr gi tract	0.69	1.87	NA	0.13	2.69	NA	XXX
74247	26	A	Contrst x-ray uppr gi tract	0.69	0.23	0.23	0.03	0.95	0.95	XXX
74247	TC	A	Contrst x-ray uppr gi tract	0.00	1.68	NA	0.11	1.79	NA	XXX
74247	.....	A	Contrst x-ray uppr gi tract	0.69	1.91	NA	0.14	2.74	NA	XXX
74249	26	A	Contrst x-ray uppr gi tract	0.91	0.30	0.30	0.04	1.25	1.25	XXX
74249	TC	A	Contrst x-ray uppr gi tract	0.00	2.58	NA	0.14	2.72	NA	XXX
74249	.....	A	Contrst x-ray uppr gi tract	0.91	2.88	NA	0.18	3.97	NA	XXX
74250	26	A	X-ray exam of small bowel	0.47	0.15	0.15	0.02	0.64	0.64	XXX
74250	TC	A	X-ray exam of small bowel	0.00	1.31	NA	0.07	1.38	NA	XXX
74250	.....	A	X-ray exam of small bowel	0.47	1.46	NA	0.09	2.02	NA	XXX
74251	26	A	X-ray exam of small bowel	0.69	0.23	0.23	0.03	0.95	0.95	XXX
74251	TC	A	X-ray exam of small bowel	0.00	1.31	NA	0.07	1.38	NA	XXX
74251	.....	A	X-ray exam of small bowel	0.69	1.54	NA	0.10	2.33	NA	XXX
74260	26	A	X-ray exam of small bowel	0.50	0.16	0.16	0.02	0.68	0.68	XXX
74260	TC	A	X-ray exam of small bowel	0.00	1.49	NA	0.08	1.57	NA	XXX
74260	.....	A	X-ray exam of small bowel	0.50	1.65	NA	0.10	2.25	NA	XXX
74270	26	A	Contrast x-ray exam of colon	0.69	0.23	0.23	0.03	0.95	0.95	XXX
74270	TC	A	Contrast x-ray exam of colon	0.00	1.70	NA	0.11	1.81	NA	XXX
74270	.....	A	Contrast x-ray exam of colon	0.69	1.93	NA	0.14	2.76	NA	XXX
74280	26	A	Contrast x-ray exam of colon	0.99	0.32	0.32	0.04	1.35	1.35	XXX
74280	TC	A	Contrast x-ray exam of colon	0.00	2.24	NA	0.13	2.37	NA	XXX
74280	.....	A	Contrast x-ray exam of colon	0.99	2.56	NA	0.17	3.72	NA	XXX
74283	26	A	Contrast x-ray exam of colon	2.02	0.66	0.66	0.09	2.77	2.77	XXX
74283	TC	A	Contrast x-ray exam of colon	0.00	2.57	NA	0.14	2.71	NA	XXX
74283	.....	A	Contrast x-ray exam of colon	2.02	3.23	NA	0.23	5.48	NA	XXX
74290	26	A	Contrast x-ray, gallbladder	0.32	0.10	0.10	0.01	0.43	0.43	XXX
74290	TC	A	Contrast x-ray, gallbladder	0.00	0.73	NA	0.05	0.78	NA	XXX
74290	.....	A	Contrast x-ray, gallbladder	0.32	0.83	NA	0.06	1.21	NA	XXX
74291	26	A	Contrast x-rays, gallbladder	0.20	0.07	0.07	0.01	0.28	0.28	XXX
74291	TC	A	Contrast x-rays, gallbladder	0.00	0.42	NA	0.02	0.44	NA	XXX
74291	.....	A	Contrast x-rays, gallbladder	0.20	0.49	NA	0.03	0.72	NA	XXX
74300	26	A	X-ray bile ducts/pancreas	0.36	0.12	0.12	0.02	0.50	0.50	XXX
74300	TC	C	X-ray bile ducts/pancreas	0.00	0.00	0.00	0.00	0.00	0.00	XXX
74300	.....	C	X-ray bile ducts/pancreas	0.00	0.00	0.00	0.00	0.00	0.00	XXX
74301	26	A	X-rays at surgery add-on	0.21	0.07	0.07	0.01	0.29	0.29	ZZZ
74301	TC	C	X-rays at surgery add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
74301	.....	C	X-rays at surgery add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
74305	26	A	X-ray bile ducts/pancreas	0.42	0.14	0.14	0.02	0.58	0.58	XXX
74305	TC	A	X-ray bile ducts/pancreas	0.00	0.78	NA	0.05	0.83	NA	XXX
74305	.....	A	X-ray bile ducts/pancreas	0.42	0.92	NA	0.07	1.41	NA	XXX
74320	26	A	Contrast x-ray of bile ducts	0.54	0.18	0.18	0.02	0.74	0.74	XXX
74320	TC	A	Contrast x-ray of bile ducts	0.00	3.16	NA	0.17	3.33	NA	XXX
74320	.....	A	Contrast x-ray of bile ducts	0.54	3.34	NA	0.19	4.07	NA	XXX
74327	26	A	X-ray bile stone removal	0.70	0.23	0.23	0.03	0.96	0.96	XXX
74327	TC	A	X-ray bile stone removal	0.00	1.77	NA	0.11	1.88	NA	XXX
74327	.....	A	X-ray bile stone removal	0.70	2.00	NA	0.14	2.84	NA	XXX
74328	26	A	X-ray bile duct endoscopy	0.70	0.23	0.23	0.03	0.96	0.96	XXX
74328	TC	A	X-ray bile duct endoscopy	0.00	3.16	NA	0.17	3.33	NA	XXX
74328	.....	A	X-ray bile duct endoscopy	0.70	3.39	NA	0.20	4.29	NA	XXX
74329	26	A	X-ray for pancreas endoscopy	0.70	0.23	0.23	0.03	0.96	0.96	XXX
74329	TC	C	X-ray for pancreas endoscopy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
74329	.....	C	X-ray for pancreas endoscopy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
74330	26	A	X-ray bile/panc endoscopy	0.90	0.29	0.29	0.04	1.23	1.23	XXX
74330	TC	A	X-ray bile/panc endoscopy	0.00	3.16	NA	0.17	3.33	NA	XXX
74330	.....	A	X-ray bile/panc endoscopy	0.90	3.45	NA	0.21	4.56	NA	XXX
74340	26	A	X-ray guide for GI tube	0.54	0.18	0.18	0.02	0.74	0.74	XXX
74340	TC	A	X-ray guide for GI tube	0.00	2.63	NA	0.14	2.77	NA	XXX
74340	.....	A	X-ray guide for GI tube	0.54	2.81	NA	0.16	3.51	NA	XXX
74350	26	A	X-ray guide, stomach tube	0.76	0.25	0.25	0.03	1.04	1.04	XXX
74350	TC	A	X-ray guide, stomach tube	0.00	3.16	NA	0.17	3.33	NA	XXX
74350	.....	A	X-ray guide, stomach tube	0.76	3.41	NA	0.20	4.37	NA	XXX
74355	26	A	X-ray guide, intestinal tube	0.76	0.25	0.25	0.03	1.04	1.04	XXX
74355	TC	A	X-ray guide, intestinal tube	0.00	2.63	NA	0.14	2.77	NA	XXX
74355	.....	A	X-ray guide, intestinal tube	0.76	2.88	NA	0.17	3.81	NA	XXX
74360	26	A	X-ray guide, GI dilation	0.54	0.19	0.19	0.02	0.75	0.75	XXX
74360	TC	A	X-ray guide, GI dilation	0.00	3.16	NA	0.17	3.33	NA	XXX
74360	.....	A	X-ray guide, GI dilation	0.54	3.35	NA	0.19	4.08	NA	XXX
74363	26	A	X-ray, bile duct dilation	0.88	0.29	0.29	0.04	1.21	1.21	XXX
74363	TC	C	X-ray, bile duct dilation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
74363	.....	C	X-ray, bile duct dilation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
74400	26	A	Contrst x-ray, urinary tract	0.49	0.16	0.16	0.02	0.67	0.67	XXX
74400	TC	A	Contrst x-ray, urinary tract	0.00	1.68	NA	0.11	1.79	NA	XXX
74400	.....	A	Contrst x-ray, urinary tract	0.49	1.84	NA	0.13	2.46	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
74410	26	A	Contrst x-ray, urinary tract	0.49	0.16	0.16	0.02	0.67	0.67	XXX
74410	TC	A	Contrst x-ray, urinary tract	0.00	1.96	NA	0.11	2.07	NA	XXX
74410	.....	A	Contrst x-ray, urinary tract	0.49	2.12	NA	0.13	2.74	NA	XXX
74415	26	A	Contrst x-ray, urinary tract	0.49	0.16	0.16	0.02	0.67	0.67	XXX
74415	TC	A	Contrst x-ray, urinary tract	0.00	2.13	NA	0.12	2.25	NA	XXX
74415	.....	A	Contrst x-ray, urinary tract	0.49	2.29	NA	0.14	2.92	NA	XXX
74420	26	A	Contrst x-ray, urinary tract	0.36	0.12	0.12	0.02	0.50	0.50	XXX
74420	TC	A	Contrst x-ray, urinary tract	0.00	2.63	NA	0.14	2.77	NA	XXX
74420	.....	A	Contrst x-ray, urinary tract	0.36	2.75	NA	0.16	3.27	NA	XXX
74425	26	A	Contrst x-ray, urinary tract	0.36	0.12	0.12	0.02	0.50	0.50	XXX
74425	TC	A	Contrst x-ray, urinary tract	0.00	1.31	NA	0.07	1.38	NA	XXX
74425	.....	A	Contrst x-ray, urinary tract	0.36	1.43	NA	0.09	1.88	NA	XXX
74430	26	A	Contrast x-ray, bladder	0.32	0.10	0.10	0.02	0.44	0.44	XXX
74430	TC	A	Contrast x-ray, bladder	0.00	1.05	NA	0.06	1.11	NA	XXX
74430	.....	A	Contrast x-ray, bladder	0.32	1.15	NA	0.08	1.55	NA	XXX
74440	26	A	X-ray, male genital tract	0.38	0.12	0.12	0.02	0.52	0.52	XXX
74440	TC	A	X-ray, male genital tract	0.00	1.13	NA	0.06	1.19	NA	XXX
74440	.....	A	X-ray, male genital tract	0.38	1.25	NA	0.08	1.71	NA	XXX
74445	26	A	X-ray exam of penis	1.14	0.37	0.37	0.07	1.58	1.58	XXX
74445	TC	A	X-ray exam of penis	0.00	1.13	NA	0.06	1.19	NA	XXX
74445	.....	A	X-ray exam of penis	1.14	1.50	NA	0.13	2.77	NA	XXX
74450	26	A	X-ray, urethra/bladder	0.33	0.11	0.11	0.02	0.46	0.46	XXX
74450	TC	A	X-ray, urethra/bladder	0.00	1.46	NA	0.08	1.54	NA	XXX
74450	.....	A	X-ray, urethra/bladder	0.33	1.57	NA	0.10	2.00	NA	XXX
74455	26	A	X-ray, urethra/bladder	0.33	0.11	0.11	0.02	0.46	0.46	XXX
74455	TC	A	X-ray, urethra/bladder	0.00	1.58	NA	0.10	1.68	NA	XXX
74455	.....	A	X-ray, urethra/bladder	0.33	1.69	NA	0.12	2.14	NA	XXX
74470	26	A	X-ray exam of kidney lesion	0.54	0.18	0.18	0.02	0.74	0.74	XXX
74470	TC	A	X-ray exam of kidney lesion	0.00	1.25	NA	0.07	1.32	NA	XXX
74470	.....	A	X-ray exam of kidney lesion	0.54	1.43	NA	0.09	2.06	NA	XXX
74475	26	A	X-ray control, cath insert	0.54	0.18	0.18	0.02	0.74	0.74	XXX
74475	TC	A	X-ray control, cath insert	0.00	4.08	NA	0.22	4.30	NA	XXX
74475	.....	A	X-ray control, cath insert	0.54	4.26	NA	0.24	5.04	NA	XXX
74480	26	A	X-ray control, cath insert	0.54	0.18	0.18	0.02	0.74	0.74	XXX
74480	TC	A	X-ray control, cath insert	0.00	4.08	NA	0.22	4.30	NA	XXX
74480	.....	A	X-ray control, cath insert	0.54	4.26	NA	0.24	5.04	NA	XXX
74485	26	A	X-ray guide, GU dilation	0.54	0.17	0.17	0.03	0.74	0.74	XXX
74485	TC	A	X-ray guide, GU dilation	0.00	3.16	NA	0.17	3.33	NA	XXX
74485	.....	A	X-ray guide, GU dilation	0.54	3.33	NA	0.20	4.07	NA	XXX
74710	26	A	X-ray measurement of pelvis	0.34	0.11	0.11	0.02	0.47	0.47	XXX
74710	TC	A	X-ray measurement of pelvis	0.00	1.05	NA	0.06	1.11	NA	XXX
74710	.....	A	X-ray measurement of pelvis	0.34	1.16	NA	0.08	1.58	NA	XXX
74740	26	A	X-ray, female genital tract	0.38	0.13	0.13	0.02	0.53	0.53	XXX
74740	TC	A	X-ray, female genital tract	0.00	1.31	NA	0.07	1.38	NA	XXX
74740	.....	A	X-ray, female genital tract	0.38	1.44	NA	0.09	1.91	NA	XXX
74742	26	A	X-ray, fallopian tube	0.61	0.20	0.20	0.03	0.84	0.84	XXX
74742	TC	C	X-ray, fallopian tube	0.00	0.00	0.00	0.00	0.00	0.00	XXX
74742	.....	C	X-ray, fallopian tube	0.00	0.00	0.00	0.00	0.00	0.00	XXX
74775	26	A	X-ray exam of perineum	0.62	0.21	0.21	0.03	0.86	0.86	XXX
74775	TC	A	X-ray exam of perineum	0.00	1.46	NA	0.08	1.54	NA	XXX
74775	.....	A	X-ray exam of perineum	0.62	1.67	NA	0.11	2.40	NA	XXX
75552	26	A	Heart mri for morph w/o dye	1.60	0.53	0.53	0.07	2.20	2.20	XXX
75552	TC	A	Heart mri for morph w/o dye	0.00	11.23	NA	0.59	11.82	NA	XXX
75552	.....	A	Heart mri for morph w/o dye	1.60	11.76	NA	0.66	14.02	NA	XXX
75553	26	A	Heart mri for morph w/dye	2.00	0.65	0.65	0.07	2.72	2.72	XXX
75553	TC	A	Heart mri for morph w/dye	0.00	11.23	NA	0.59	11.82	NA	XXX
75553	.....	A	Heart mri for morph w/dye	2.00	11.88	NA	0.66	14.54	NA	XXX
75554	26	A	Cardiac MRI/function	1.83	0.64	0.64	0.07	2.54	2.54	XXX
75554	TC	A	Cardiac MRI/function	0.00	11.23	NA	0.59	11.82	NA	XXX
75554	.....	A	Cardiac MRI/function	1.83	11.87	NA	0.66	14.36	NA	XXX
75555	26	A	Cardiac MRI/limited study	1.74	0.64	0.64	0.07	2.45	2.45	XXX
75555	TC	A	Cardiac MRI/limited study	0.00	11.23	NA	0.59	11.82	NA	XXX
75555	.....	A	Cardiac MRI/limited study	1.74	11.87	NA	0.66	14.27	NA	XXX
75556	.....	N	Cardiac MRI/flow mapping	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75600	26	A	Contrast x-ray exam of aorta	0.49	0.19	0.19	0.02	0.70	0.70	XXX
75600	TC	A	Contrast x-ray exam of aorta	0.00	12.64	NA	0.65	13.29	NA	XXX
75600	.....	A	Contrast x-ray exam of aorta	0.49	12.83	NA	0.67	13.99	NA	XXX
75605	26	A	Contrast x-ray exam of aorta	1.14	0.40	0.40	0.05	1.59	1.59	XXX
75605	TC	A	Contrast x-ray exam of aorta	0.00	12.64	NA	0.65	13.29	NA	XXX
75605	.....	A	Contrast x-ray exam of aorta	1.14	13.04	NA	0.70	14.88	NA	XXX
75625	26	A	Contrast x-ray exam of aorta	1.14	0.38	0.38	0.06	1.58	1.58	XXX
75625	TC	A	Contrast x-ray exam of aorta	0.00	12.64	NA	0.65	13.29	NA	XXX
75625	.....	A	Contrast x-ray exam of aorta	1.14	13.02	NA	0.71	14.87	NA	XXX
75630	26	A	X-ray aorta, leg arteries	1.79	0.61	0.61	0.11	2.51	2.51	XXX
75630	TC	A	X-ray aorta, leg arteries	0.00	13.17	NA	0.69	13.86	NA	XXX

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[3] +Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
75630	.....	A	X-ray aorta, leg arteries	1.79	13.78	NA	0.80	16.37	NA	XXX
75635	26	A	Ct angio abdominal arteries	2.40	0.79	0.79	0.11	3.30	3.30	XXX
75635	TC	A	Ct angio abdominal arteries	0.00	15.96	NA	0.39	16.35	NA	XXX
75635	.....	A	Ct angio abdominal arteries	2.40	16.75	NA	0.50	19.65	NA	XXX
75650	26	A	Artery x-rays, head & neck	1.49	0.49	0.49	0.07	2.05	2.05	XXX
75650	TC	A	Artery x-rays, head & neck	0.00	12.64	NA	0.65	13.29	NA	XXX
75650	.....	A	Artery x-rays, head & neck	1.49	13.13	NA	0.72	15.34	NA	XXX
75658	26	A	Artery x-rays, arm	1.31	0.47	0.47	0.07	1.85	1.85	XXX
75658	TC	A	Artery x-rays, arm	0.00	12.64	NA	0.65	13.29	NA	XXX
75658	.....	A	Artery x-rays, arm	1.31	13.11	NA	0.72	15.14	NA	XXX
75660	26	A	Artery x-rays, head & neck	1.31	0.44	0.44	0.06	1.81	1.81	XXX
75660	TC	A	Artery x-rays, head & neck	0.00	12.64	NA	0.65	13.29	NA	XXX
75660	.....	A	Artery x-rays, head & neck	1.31	13.08	NA	0.71	15.10	NA	XXX
75662	26	A	Artery x-rays, head & neck	1.66	0.59	0.59	0.06	2.31	2.31	XXX
75662	TC	A	Artery x-rays, head & neck	0.00	12.64	NA	0.65	13.29	NA	XXX
75662	.....	A	Artery x-rays, head & neck	1.66	13.23	NA	0.71	15.60	NA	XXX
75665	26	A	Artery x-rays, head & neck	1.31	0.44	0.44	0.09	1.84	1.84	XXX
75665	TC	A	Artery x-rays, head & neck	0.00	12.64	NA	0.65	13.29	NA	XXX
75665	.....	A	Artery x-rays, head & neck	1.31	13.08	NA	0.74	15.13	NA	XXX
75671	26	A	Artery x-rays, head & neck	1.66	0.55	0.55	0.07	2.28	2.28	XXX
75671	TC	A	Artery x-rays, head & neck	0.00	12.64	NA	0.65	13.29	NA	XXX
75671	.....	A	Artery x-rays, head & neck	1.66	13.19	NA	0.72	15.57	NA	XXX
75676	26	A	Artery x-rays, neck	1.31	0.44	0.44	0.07	1.82	1.82	XXX
75676	TC	A	Artery x-rays, neck	0.00	12.64	NA	0.65	13.29	NA	XXX
75676	.....	A	Artery x-rays, neck	1.31	13.08	NA	0.72	15.11	NA	XXX
75680	26	A	Artery x-rays, neck	1.66	0.55	0.55	0.07	2.28	2.28	XXX
75680	TC	A	Artery x-rays, neck	0.00	12.64	NA	0.65	13.29	NA	XXX
75680	.....	A	Artery x-rays, neck	1.66	13.19	NA	0.72	15.57	NA	XXX
75685	26	A	Artery x-rays, spine	1.31	0.43	0.43	0.06	1.80	1.80	XXX
75685	TC	A	Artery x-rays, spine	0.00	12.64	NA	0.65	13.29	NA	XXX
75685	.....	A	Artery x-rays, spine	1.31	13.07	NA	0.71	15.09	NA	XXX
75705	26	A	Artery x-rays, spine	2.18	0.73	0.73	0.13	3.04	3.04	XXX
75705	TC	A	Artery x-rays, spine	0.00	12.64	NA	0.65	13.29	NA	XXX
75705	.....	A	Artery x-rays, spine	2.18	13.37	NA	0.78	16.33	NA	XXX
75710	26	A	Artery x-rays, arm/leg	1.14	0.39	0.39	0.07	1.60	1.60	XXX
75710	TC	A	Artery x-rays, arm/leg	0.00	12.64	NA	0.65	13.29	NA	XXX
75710	.....	A	Artery x-rays, arm/leg	1.14	13.03	NA	0.72	14.89	NA	XXX
75716	26	A	Artery x-rays, arms/legs	1.31	0.43	0.43	0.07	1.81	1.81	XXX
75716	TC	A	Artery x-rays, arms/legs	0.00	12.64	NA	0.65	13.29	NA	XXX
75716	.....	A	Artery x-rays, arms/legs	1.31	13.07	NA	0.72	15.10	NA	XXX
75722	26	A	Artery x-rays, kidney	1.14	0.40	0.40	0.05	1.59	1.59	XXX
75722	TC	A	Artery x-rays, kidney	0.00	12.64	NA	0.65	13.29	NA	XXX
75722	.....	A	Artery x-rays, kidney	1.14	13.04	NA	0.70	14.88	NA	XXX
75724	26	A	Artery x-rays, kidneys	1.49	0.56	0.56	0.05	2.10	2.10	XXX
75724	TC	A	Artery x-rays, kidneys	0.00	12.64	NA	0.65	13.29	NA	XXX
75724	.....	A	Artery x-rays, kidneys	1.49	13.20	NA	0.70	15.39	NA	XXX
75726	26	A	Artery x-rays, abdomen	1.14	0.37	0.37	0.05	1.56	1.56	XXX
75726	TC	A	Artery x-rays, abdomen	0.00	12.64	NA	0.65	13.29	NA	XXX
75726	.....	A	Artery x-rays, abdomen	1.14	13.01	NA	0.70	14.85	NA	XXX
75731	26	A	Artery x-rays, adrenal gland	1.14	0.37	0.37	0.06	1.57	1.57	XXX
75731	TC	A	Artery x-rays, adrenal gland	0.00	12.64	NA	0.65	13.29	NA	XXX
75731	.....	A	Artery x-rays, adrenal gland	1.14	13.01	NA	0.71	14.86	NA	XXX
75733	26	A	Artery x-rays, adrenals	1.31	0.44	0.44	0.06	1.81	1.81	XXX
75733	TC	A	Artery x-rays, adrenals	0.00	12.64	NA	0.65	13.29	NA	XXX
75733	.....	A	Artery x-rays, adrenals	1.31	13.08	NA	0.71	15.10	NA	XXX
75736	26	A	Artery x-rays, pelvis	1.14	0.38	0.38	0.06	1.58	1.58	XXX
75736	TC	A	Artery x-rays, pelvis	0.00	12.64	NA	0.65	13.29	NA	XXX
75736	.....	A	Artery x-rays, pelvis	1.14	13.02	NA	0.71	14.87	NA	XXX
75741	26	A	Artery x-rays, lung	1.31	0.43	0.43	0.06	1.80	1.80	XXX
75741	TC	A	Artery x-rays, lung	0.00	12.64	NA	0.65	13.29	NA	XXX
75741	.....	A	Artery x-rays, lung	1.31	13.07	NA	0.71	15.09	NA	XXX
75743	26	A	Artery x-rays, lungs	1.66	0.54	0.54	0.07	2.27	2.27	XXX
75743	TC	A	Artery x-rays, lungs	0.00	12.64	NA	0.65	13.29	NA	XXX
75743	.....	A	Artery x-rays, lungs	1.66	13.18	NA	0.72	15.56	NA	XXX
75746	26	A	Artery x-rays, lung	1.14	0.38	0.38	0.05	1.57	1.57	XXX
75746	TC	A	Artery x-rays, lung	0.00	12.64	NA	0.65	13.29	NA	XXX
75746	.....	A	Artery x-rays, lung	1.14	13.02	NA	0.70	14.86	NA	XXX
75756	26	A	Artery x-rays, chest	1.14	0.45	0.45	0.04	1.63	1.63	XXX
75756	TC	A	Artery x-rays, chest	0.00	12.64	NA	0.65	13.29	NA	XXX
75756	.....	A	Artery x-rays, chest	1.14	13.09	NA	0.69	14.92	NA	XXX
75774	26	A	Artery x-ray, each vessel	0.36	0.12	0.12	0.02	0.50	0.50	ZZZ
75774	TC	A	Artery x-ray, each vessel	0.00	12.64	NA	0.65	13.29	NA	ZZZ
75774	.....	A	Artery x-ray, each vessel	0.36	12.76	NA	0.67	13.79	NA	ZZZ
75790	26	A	Visualize A-V shunt	1.84	0.60	0.60	0.09	2.53	2.53	XXX
75790	TC	A	Visualize A-V shunt	0.00	1.35	NA	0.08	1.43	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
75790	.....	A	Visualize A-V shunt	1.84	1.95	NA	0.17	3.96	NA	XXX
75801	26	A	Lymph vessel x-ray, arm/leg	0.81	0.27	0.27	0.08	1.16	1.16	XXX
75801	TC	A	Lymph vessel x-ray, arm/leg	0.00	5.43	NA	0.29	5.72	NA	XXX
75801	.....	A	Lymph vessel x-ray, arm/leg	0.81	5.70	NA	0.37	6.88	NA	XXX
75803	26	A	Lymph vessel x-ray,arms/legs	1.17	0.38	0.38	0.05	1.60	1.60	XXX
75803	TC	A	Lymph vessel x-ray,arms/legs	0.00	5.43	NA	0.29	5.72	NA	XXX
75803	.....	A	Lymph vessel x-ray,arms/legs	1.17	5.81	NA	0.34	7.32	NA	XXX
75805	26	A	Lymph vessel x-ray, trunk	0.81	0.27	0.27	0.05	1.13	1.13	XXX
75805	TC	A	Lymph vessel x-ray, trunk	0.00	6.12	NA	0.33	6.45	NA	XXX
75805	.....	A	Lymph vessel x-ray, trunk	0.81	6.39	NA	0.38	7.58	NA	XXX
75807	26	A	Lymph vessel x-ray, trunk	1.17	0.38	0.38	0.05	1.60	1.60	XXX
75807	TC	C	Lymph vessel x-ray, trunk	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75807	.....	C	Lymph vessel x-ray, trunk	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75809	26	A	Nonvascular shunt, x-ray	0.47	0.15	0.15	0.02	0.64	0.64	XXX
75809	TC	A	Nonvascular shunt, x-ray	0.00	0.78	NA	0.05	0.83	NA	XXX
75809	.....	A	Nonvascular shunt, x-ray	0.47	0.93	NA	0.07	1.47	NA	XXX
75810	26	A	Vein x-ray, spleen/liver	1.14	0.37	0.37	0.05	1.56	1.56	XXX
75810	TC	A	Vein x-ray, spleen/liver	0.00	12.64	NA	0.65	13.29	NA	XXX
75810	.....	A	Vein x-ray, spleen/liver	1.14	13.01	NA	0.70	14.85	NA	XXX
75820	26	A	Vein x-ray, arm/leg	0.70	0.23	0.23	0.03	0.96	0.96	XXX
75820	TC	A	Vein x-ray, arm/leg	0.00	0.95	NA	0.06	1.01	NA	XXX
75820	.....	A	Vein x-ray, arm/leg	0.70	1.18	NA	0.09	1.97	NA	XXX
75822	26	A	Vein x-ray, arms/legs	1.06	0.35	0.35	0.05	1.46	1.46	XXX
75822	TC	A	Vein x-ray, arms/legs	0.00	1.48	NA	0.08	1.56	NA	XXX
75822	.....	A	Vein x-ray, arms/legs	1.06	1.83	NA	0.13	3.02	NA	XXX
75825	26	A	Vein x-ray, trunk	1.14	0.37	0.37	0.07	1.58	1.58	XXX
75825	TC	A	Vein x-ray, trunk	0.00	12.64	NA	0.65	13.29	NA	XXX
75825	.....	A	Vein x-ray, trunk	1.14	13.01	NA	0.72	14.87	NA	XXX
75827	26	A	Vein x-ray, chest	1.14	0.37	0.37	0.05	1.56	1.56	XXX
75827	TC	A	Vein x-ray, chest	0.00	12.64	NA	0.65	13.29	NA	XXX
75827	.....	A	Vein x-ray, chest	1.14	13.01	NA	0.70	14.85	NA	XXX
75831	26	A	Vein x-ray, kidney	1.14	0.37	0.37	0.06	1.57	1.57	XXX
75831	TC	A	Vein x-ray, kidney	0.00	12.64	NA	0.65	13.29	NA	XXX
75831	.....	A	Vein x-ray, kidney	1.14	13.01	NA	0.71	14.86	NA	XXX
75833	26	A	Vein x-ray, kidneys	1.49	0.49	0.49	0.09	2.07	2.07	XXX
75833	TC	A	Vein x-ray, kidneys	0.00	12.64	NA	0.65	13.29	NA	XXX
75833	.....	A	Vein x-ray, kidneys	1.49	13.13	NA	0.74	15.36	NA	XXX
75840	26	A	Vein x-ray, adrenal gland	1.14	0.38	0.38	0.07	1.59	1.59	XXX
75840	TC	A	Vein x-ray, adrenal gland	0.00	12.64	NA	0.65	13.29	NA	XXX
75840	.....	A	Vein x-ray, adrenal gland	1.14	13.02	NA	0.72	14.88	NA	XXX
75842	26	A	Vein x-ray, adrenal glands	1.49	0.48	0.48	0.07	2.04	2.04	XXX
75842	TC	A	Vein x-ray, adrenal glands	0.00	12.64	NA	0.65	13.29	NA	XXX
75842	.....	A	Vein x-ray, adrenal glands	1.49	13.12	NA	0.72	15.33	NA	XXX
75860	26	A	Vein x-ray, neck	1.14	0.39	0.39	0.04	1.57	1.57	XXX
75860	TC	A	Vein x-ray, neck	0.00	12.64	NA	0.65	13.29	NA	XXX
75860	.....	A	Vein x-ray, neck	1.14	13.03	NA	0.69	14.86	NA	XXX
75870	26	A	Vein x-ray, skull	1.14	0.39	0.39	0.05	1.58	1.58	XXX
75870	TC	A	Vein x-ray, skull	0.00	12.64	NA	0.65	13.29	NA	XXX
75870	.....	A	Vein x-ray, skull	1.14	13.03	NA	0.70	14.87	NA	XXX
75872	26	A	Vein x-ray, skull	1.14	0.37	0.37	0.14	1.65	1.65	XXX
75872	TC	A	Vein x-ray, skull	0.00	12.64	NA	0.65	13.29	NA	XXX
75872	.....	A	Vein x-ray, skull	1.14	13.01	NA	0.79	14.94	NA	XXX
75880	26	A	Vein x-ray, eye socket	0.70	0.23	0.23	0.03	0.96	0.96	XXX
75880	TC	A	Vein x-ray, eye socket	0.00	0.95	NA	0.06	1.01	NA	XXX
75880	.....	A	Vein x-ray, eye socket	0.70	1.18	NA	0.09	1.97	NA	XXX
75885	26	A	Vein x-ray, liver	1.44	0.47	0.47	0.06	1.97	1.97	XXX
75885	TC	A	Vein x-ray, liver	0.00	12.64	NA	0.65	13.29	NA	XXX
75885	.....	A	Vein x-ray, liver	1.44	13.11	NA	0.71	15.26	NA	XXX
75887	26	A	Vein x-ray, liver	1.44	0.47	0.47	0.06	1.97	1.97	XXX
75887	TC	A	Vein x-ray, liver	0.00	12.64	NA	0.65	13.29	NA	XXX
75887	.....	A	Vein x-ray, liver	1.44	13.11	NA	0.71	15.26	NA	XXX
75889	26	A	Vein x-ray, liver	1.14	0.37	0.37	0.05	1.56	1.56	XXX
75889	TC	A	Vein x-ray, liver	0.00	12.64	NA	0.65	13.29	NA	XXX
75889	.....	A	Vein x-ray, liver	1.14	13.01	NA	0.70	14.85	NA	XXX
75891	26	A	Vein x-ray, liver	1.14	0.37	0.37	0.05	1.56	1.56	XXX
75891	TC	A	Vein x-ray, liver	0.00	12.64	NA	0.65	13.29	NA	XXX
75891	.....	A	Vein x-ray, liver	1.14	13.01	NA	0.70	14.85	NA	XXX
75893	26	A	Venous sampling by catheter	0.54	0.18	0.18	0.02	0.74	0.74	XXX
75893	TC	A	Venous sampling by catheter	0.00	12.64	NA	0.65	13.29	NA	XXX
75893	.....	A	Venous sampling by catheter	0.54	12.82	NA	0.67	14.03	NA	XXX
75894	26	A	X-rays, transcath therapy	1.31	0.43	0.43	0.08	1.82	1.82	XXX
75894	TC	A	X-rays, transcath therapy	0.00	24.20	NA	1.27	25.47	NA	XXX
75894	.....	A	X-rays, transcath therapy	1.31	24.63	NA	1.35	27.29	NA	XXX
75896	26	A	X-rays, transcath therapy	1.31	0.45	0.45	0.05	1.81	1.81	XXX
75896	TC	A	X-rays, transcath therapy	0.00	21.05	NA	1.10	22.15	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
75896	.....	A	X-rays, transcath therapy	1.31	21.50	NA	1.15	23.96	NA	XXX
75898	26	A	Follow-up angiography	1.65	0.55	0.55	0.07	2.27	2.27	XXX
75898	TC	A	Follow-up angiography	0.00	1.05	NA	0.06	1.11	NA	XXX
75898	.....	A	Follow-up angiography	1.65	1.60	NA	0.13	3.38	NA	XXX
75900	26	A	Intravascular cath exchange	0.49	0.16	0.16	0.03	0.68	0.68	XXX
75900	TC	C	Intravascular cath exchange	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75900	.....	C	Intravascular cath exchange	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75901	26	A	Remove cva device obstruct	0.49	0.16	0.16	0.02	0.67	0.67	XXX
75901	TC	A	Remove cva device obstruct	0.00	1.31	NA	0.83	2.14	NA	XXX
75901	.....	A	Remove cva device obstruct	0.49	1.47	NA	0.85	2.81	NA	XXX
75902	26	A	Remove cva lumen obstruct	0.39	0.13	0.13	0.02	0.54	0.54	XXX
75902	TC	A	Remove cva lumen obstruct	0.00	1.31	NA	0.83	2.14	NA	XXX
75902	.....	A	Remove cva lumen obstruct	0.39	1.44	NA	0.85	2.68	NA	XXX
75940	26	A	X-ray placement, vein filter	0.54	0.18	0.18	0.04	0.76	0.76	XXX
75940	TC	A	X-ray placement, vein filter	0.00	12.64	NA	0.65	13.29	NA	XXX
75940	.....	A	X-ray placement, vein filter	0.54	12.82	NA	0.69	14.05	NA	XXX
75945	26	A	Intravascular us	0.40	0.14	0.14	0.04	0.58	0.58	XXX
75945	TC	A	Intravascular us	0.00	4.57	NA	0.24	4.81	NA	XXX
75945	.....	A	Intravascular us	0.40	4.71	NA	0.28	5.39	NA	XXX
75946	26	A	Intravascular us add-on	0.40	0.14	0.14	0.05	0.59	0.59	ZZZ
75946	TC	C	Intravascular us add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
75946	.....	C	Intravascular us add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
75952	26	A	Endovasc repair abdom aorta	4.49	1.49	1.49	0.43	6.41	6.41	XXX
75952	TC	C	Endovasc repair abdom aorta	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75952	.....	C	Endovasc repair abdom aorta	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75953	26	A	Abdom aneurysm endovas rpr	1.36	0.45	0.45	0.13	1.94	1.94	XXX
75953	TC	C	Abdom aneurysm endovas rpr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75953	.....	C	Abdom aneurysm endovas rpr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75954	26	A	Iliac aneurysm endovas rpr	2.25	0.78	0.78	0.15	3.18	3.18	XXX
75954	TC	C	Iliac aneurysm endovas rpr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75954	.....	C	Iliac aneurysm endovas rpr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75956	26	A	Xray, endovasc thor ao repr	7.00	2.71	2.71	0.69	10.40	10.40	XXX
75956	TC	C	Xray, endovasc thor ao repr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75956	.....	C	Xray, endovasc thor ao repr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75957	26	A	Xray, endovasc thor ao repr	6.00	2.32	2.32	0.59	8.91	8.91	XXX
75957	TC	C	Xray, endovasc thor ao repr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75957	.....	C	Xray, endovasc thor ao repr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75958	26	A	Xray, place prox ext thor ao	4.00	1.55	1.55	0.39	5.94	5.94	XXX
75958	TC	C	Xray, place prox ext thor ao	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75958	.....	C	Xray, place prox ext thor ao	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75959	26	A	Xray, place dist ext thor ao	3.50	1.36	1.36	0.34	5.20	5.20	XXX
75959	TC	C	Xray, place dist ext thor ao	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75959	.....	C	Xray, place dist ext thor ao	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75960	26	A	Transcath iv stent rs&i	0.82	0.28	0.28	0.05	1.15	1.15	XXX
75960	TC	A	Transcath iv stent rs&i	0.00	14.94	NA	0.77	15.71	NA	XXX
75960	.....	A	Transcath iv stent rs&i	0.82	15.22	NA	0.82	16.86	NA	XXX
75961	26	A	Retrieval, broken catheter	4.24	1.39	1.39	0.18	5.81	5.81	XXX
75961	TC	A	Retrieval, broken catheter	0.00	10.53	NA	0.55	11.08	NA	XXX
75961	.....	A	Retrieval, broken catheter	4.24	11.92	NA	0.73	16.89	NA	XXX
75962	26	A	Repair arterial blockage	0.54	0.18	0.18	0.03	0.75	0.75	XXX
75962	TC	A	Repair arterial blockage	0.00	15.79	NA	0.83	16.62	NA	XXX
75962	.....	A	Repair arterial blockage	0.54	15.97	NA	0.86	17.37	NA	XXX
75964	26	A	Repair artery blockage, each	0.36	0.12	0.12	0.03	0.51	0.51	ZZZ
75964	TC	A	Repair artery blockage, each	0.00	8.41	NA	0.43	8.84	NA	ZZZ
75964	.....	A	Repair artery blockage, each	0.36	8.53	NA	0.46	9.35	NA	ZZZ
75966	26	A	Repair arterial blockage	1.31	0.46	0.46	0.06	1.83	1.83	XXX
75966	TC	A	Repair arterial blockage	0.00	15.79	NA	0.83	16.62	NA	XXX
75966	.....	A	Repair arterial blockage	1.31	16.25	NA	0.89	18.45	NA	XXX
75968	26	A	Repair artery blockage, each	0.36	0.13	0.13	0.02	0.51	0.51	ZZZ
75968	TC	A	Repair artery blockage, each	0.00	8.41	NA	0.43	8.84	NA	ZZZ
75968	.....	A	Repair artery blockage, each	0.36	8.54	NA	0.45	9.35	NA	ZZZ
75970	26	A	Vascular biopsy	0.83	0.28	0.28	0.04	1.15	1.15	XXX
75970	TC	A	Vascular biopsy	0.00	11.57	NA	0.60	12.17	NA	XXX
75970	.....	A	Vascular biopsy	0.83	11.85	NA	0.64	13.32	NA	XXX
75978	26	A	Repair venous blockage	0.54	0.18	0.18	0.02	0.74	0.74	XXX
75978	TC	A	Repair venous blockage	0.00	15.79	NA	0.83	16.62	NA	XXX
75978	.....	A	Repair venous blockage	0.54	15.97	NA	0.85	17.36	NA	XXX
75980	26	A	Contrast xray exam bile duct	1.44	0.47	0.47	0.06	1.97	1.97	XXX
75980	TC	A	Contrast xray exam bile duct	0.00	5.43	NA	0.29	5.72	NA	XXX
75980	.....	A	Contrast xray exam bile duct	1.44	5.90	NA	0.35	7.69	NA	XXX
75982	26	A	Contrast xray exam bile duct	1.44	0.47	0.47	0.06	1.97	1.97	XXX
75982	TC	C	Contrast xray exam bile duct	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75982	.....	C	Contrast xray exam bile duct	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75984	26	A	Xray control catheter change	0.72	0.23	0.23	0.03	0.98	0.98	XXX
75984	TC	A	Xray control catheter change	0.00	1.96	NA	0.11	2.07	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
75984	.....	A	Xray control catheter change	0.72	2.19	NA	0.14	3.05	NA	XXX
75989	26	A	Abscess drainage under x-ray	1.19	0.39	0.39	0.05	1.63	1.63	XXX
75989	TC	A	Abscess drainage under x-ray	0.00	3.16	NA	0.17	3.33	NA	XXX
75989	.....	A	Abscess drainage under x-ray	1.19	3.55	NA	0.22	4.96	NA	XXX
75992	26	A	Atherectomy, x-ray exam	0.54	0.19	0.19	0.03	0.76	0.76	XXX
75992	TC	A	Atherectomy, x-ray exam	0.00	15.79	NA	0.83	16.62	NA	XXX
75992	.....	A	Atherectomy, x-ray exam	0.54	15.98	NA	0.86	17.38	NA	XXX
75993	26	A	Atherectomy, x-ray exam	0.36	0.13	0.13	0.02	0.51	0.51	ZZZ
75993	TC	C	Atherectomy, x-ray exam	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
75993	.....	C	Atherectomy, x-ray exam	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
75994	26	A	Atherectomy, x-ray exam	1.31	0.46	0.46	0.07	1.84	1.84	XXX
75994	TC	C	Atherectomy, x-ray exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75994	.....	C	Atherectomy, x-ray exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75995	26	A	Atherectomy, x-ray exam	1.31	0.47	0.47	0.05	1.83	1.83	XXX
75995	TC	C	Atherectomy, x-ray exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75995	.....	C	Atherectomy, x-ray exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75996	26	A	Atherectomy, x-ray exam	0.36	0.12	0.12	0.02	0.50	0.50	ZZZ
75996	TC	C	Atherectomy, x-ray exam	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
75996	.....	C	Atherectomy, x-ray exam	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
75998	26	A	Fluoroguide for vein device	0.38	0.13	0.13	0.01	0.52	0.52	ZZZ
75998	TC	A	Fluoroguide for vein device	0.00	1.31	NA	0.10	1.41	NA	ZZZ
75998	.....	A	Fluoroguide for vein device	0.38	1.44	NA	0.11	1.93	NA	ZZZ
76000	26	A	Fluoroscope examination	0.17	0.05	0.05	0.01	0.23	0.23	XXX
76000	TC	A	Fluoroscope examination	0.00	1.31	NA	0.07	1.38	NA	XXX
76000	.....	A	Fluoroscope examination	0.17	1.36	NA	0.08	1.61	NA	XXX
76001	26	A	Fluoroscope exam, extensive	0.67	0.22	0.22	0.05	0.94	0.94	XXX
76001	TC	A	Fluoroscope exam, extensive	0.00	2.63	NA	0.14	2.77	NA	XXX
76001	.....	A	Fluoroscope exam, extensive	0.67	2.85	NA	0.19	3.71	NA	XXX
76003	26	A	Needle localization by x-ray	0.54	0.17	0.17	0.02	0.73	0.73	XXX
76003	TC	A	Needle localization by x-ray	0.00	1.31	NA	0.07	1.38	NA	XXX
76003	.....	A	Needle localization by x-ray	0.54	1.48	NA	0.09	2.11	NA	XXX
76005	26	A	Fluoroguide for spine inject	0.60	0.15	0.15	0.03	0.78	0.78	XXX
76005	TC	A	Fluoroguide for spine inject	0.00	1.31	NA	0.07	1.38	NA	XXX
76005	.....	A	Fluoroguide for spine inject	0.60	1.46	NA	0.10	2.16	NA	XXX
76006	.....	A	X-ray stress view	0.41	0.18	0.18	0.06	0.65	0.65	XXX
76010	26	A	X-ray, nose to rectum	0.18	0.06	0.06	0.01	0.25	0.25	XXX
76010	TC	A	X-ray, nose to rectum	0.00	0.52	NA	0.02	0.54	NA	XXX
76010	.....	A	X-ray, nose to rectum	0.18	0.58	NA	0.03	0.79	NA	XXX
76012	26	A	Percut vertebroplasty fluor	1.31	0.47	0.47	0.10	1.88	1.88	XXX
76012	TC	C	Percut vertebroplasty fluor	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76012	.....	C	Percut vertebroplasty fluor	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76013	26	A	Percut vertebroplasty, ct	1.38	0.48	0.48	0.07	1.93	1.93	XXX
76013	TC	C	Percut vertebroplasty, ct	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76013	.....	C	Percut vertebroplasty, ct	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76020	26	A	X-rays for bone age	0.19	0.06	0.06	0.01	0.26	0.26	XXX
76020	TC	A	X-rays for bone age	0.00	0.52	NA	0.02	0.54	NA	XXX
76020	.....	A	X-rays for bone age	0.19	0.58	NA	0.03	0.80	NA	XXX
76040	26	A	X-rays, bone evaluation	0.27	0.09	0.09	0.01	0.37	0.37	XXX
76040	TC	A	X-rays, bone evaluation	0.00	0.78	NA	0.05	0.83	NA	XXX
76040	.....	A	X-rays, bone evaluation	0.27	0.87	NA	0.06	1.20	NA	XXX
76061	26	A	X-rays, bone survey	0.45	0.15	0.15	0.02	0.62	0.62	XXX
76061	TC	A	X-rays, bone survey	0.00	1.00	NA	0.06	1.06	NA	XXX
76061	.....	A	X-rays, bone survey	0.45	1.15	NA	0.08	1.68	NA	XXX
76062	26	A	X-rays, bone survey	0.54	0.18	0.18	0.02	0.74	0.74	XXX
76062	TC	A	X-rays, bone survey	0.00	1.44	NA	0.08	1.52	NA	XXX
76062	.....	A	X-rays, bone survey	0.54	1.62	NA	0.10	2.26	NA	XXX
76065	26	A	X-rays, bone evaluation	0.70	0.23	0.23	0.03	0.96	0.96	XXX
76065	TC	A	X-rays, bone evaluation	0.00	0.73	NA	0.05	0.78	NA	XXX
76065	.....	A	X-rays, bone evaluation	0.70	0.96	NA	0.08	1.74	NA	XXX
76066	26	A	Joint survey, single view	0.31	0.10	0.10	0.02	0.43	0.43	XXX
76066	TC	A	Joint survey, single view	0.00	1.11	NA	0.06	1.17	NA	XXX
76066	.....	A	Joint survey, single view	0.31	1.21	NA	0.08	1.60	NA	XXX
76070	26	A	Ct bone density, axial	0.25	0.08	0.08	0.01	0.34	0.34	XXX
76070	TC	A	Ct bone density, axial	0.00	2.96	NA	0.16	3.12	NA	XXX
76070	.....	A	Ct bone density, axial	0.25	3.04	NA	0.17	3.46	NA	XXX
76071	26	A	Ct bone density, peripheral	0.22	0.07	0.07	0.01	0.30	0.30	XXX
76071	TC	A	Ct bone density, peripheral	0.00	2.96	NA	0.05	3.01	NA	XXX
76071	.....	A	Ct bone density, peripheral	0.22	3.03	NA	0.06	3.31	NA	XXX
76075	26	A	Dxa bone density, axial	0.30	0.10	0.10	0.01	0.41	0.41	XXX
76075	TC	A	Dxa bone density, axial	0.00	3.10	NA	0.17	3.27	NA	XXX
76075	.....	A	Dxa bone density, axial	0.30	3.20	NA	0.18	3.68	NA	XXX
76076	26	A	Dxa bone density/peripheral	0.22	0.08	0.08	0.01	0.31	0.31	XXX
76076	TC	A	Dxa bone density/peripheral	0.00	0.75	NA	0.05	0.80	NA	XXX
76076	.....	A	Dxa bone density/peripheral	0.22	0.83	NA	0.06	1.11	NA	XXX
76077	26	A	Dxa bone density/v-fracture	0.17	0.06	0.06	0.01	0.24	0.24	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
76077	TC	A	Dxa bone density/v-fracture	0.00	0.75	NA	0.05	0.80	NA	XXX
76077	.....	A	Dxa bone density/v-fracture	0.17	0.81	NA	0.06	1.04	NA	XXX
76078	26	A	Radiographic absorptiometry	0.20	0.07	0.07	0.01	0.28	0.28	XXX
76078	TC	A	Radiographic absorptiometry	0.00	0.75	NA	0.05	0.80	NA	XXX
76078	.....	A	Radiographic absorptiometry	0.20	0.82	NA	0.06	1.08	NA	XXX
76080	26	A	X-ray exam of fistula	0.54	0.18	0.18	0.02	0.74	0.74	XXX
76080	TC	A	X-ray exam of fistula	0.00	1.05	NA	0.06	1.11	NA	XXX
76080	.....	A	X-ray exam of fistula	0.54	1.23	NA	0.08	1.85	NA	XXX
76082	26	A	Computer mammogram add-on	0.06	0.02	0.02	0.01	0.09	0.09	ZZZ
76082	TC	A	Computer mammogram add-on	0.00	0.42	NA	0.01	0.43	NA	ZZZ
76082	.....	A	Computer mammogram add-on	0.06	0.44	NA	0.02	0.52	NA	ZZZ
76083	26	A	Computer mammogram add-on	0.06	0.02	0.02	0.01	0.09	0.09	ZZZ
76083	TC	A	Computer mammogram add-on	0.00	0.42	NA	0.01	0.43	NA	ZZZ
76083	.....	A	Computer mammogram add-on	0.06	0.44	NA	0.02	0.52	NA	ZZZ
76086	26	A	X-ray of mammary duct	0.36	0.12	0.12	0.02	0.50	0.50	XXX
76086	TC	A	X-ray of mammary duct	0.00	2.63	NA	0.14	2.77	NA	XXX
76086	.....	A	X-ray of mammary duct	0.36	2.75	NA	0.16	3.27	NA	XXX
76088	26	A	X-ray of mammary ducts	0.45	0.15	0.15	0.02	0.62	0.62	XXX
76088	TC	A	X-ray of mammary ducts	0.00	3.67	NA	0.19	3.86	NA	XXX
76088	.....	A	X-ray of mammary ducts	0.45	3.82	NA	0.21	4.48	NA	XXX
76090	26	A	Mammogram, one breast	0.70	0.23	0.23	0.03	0.96	0.96	XXX
76090	TC	A	Mammogram, one breast	0.00	1.05	NA	0.06	1.11	NA	XXX
76090	.....	A	Mammogram, one breast	0.70	1.28	NA	0.09	2.07	NA	XXX
76091	26	A	Mammogram, both breasts	0.87	0.28	0.28	0.04	1.19	1.19	XXX
76091	TC	A	Mammogram, both breasts	0.00	1.31	NA	0.07	1.38	NA	XXX
76091	.....	A	Mammogram, both breasts	0.87	1.59	NA	0.11	2.57	NA	XXX
76092	26	A	Mammogram, screening	0.70	0.23	0.23	0.03	0.96	0.96	XXX
76092	TC	A	Mammogram, screening	0.00	1.23	NA	0.07	1.30	NA	XXX
76092	.....	A	Mammogram, screening	0.70	1.46	NA	0.10	2.26	NA	XXX
76093	26	A	Magnetic image, breast	1.63	0.53	0.53	0.07	2.23	2.23	XXX
76093	TC	A	Magnetic image, breast	0.00	17.67	NA	0.92	18.59	NA	XXX
76093	.....	A	Magnetic image, breast	1.63	18.20	NA	0.99	20.82	NA	XXX
76094	26	A	Magnetic image, both breasts	1.63	0.53	0.53	0.07	2.23	2.23	XXX
76094	TC	A	Magnetic image, both breasts	0.00	23.98	NA	1.24	25.22	NA	XXX
76094	.....	A	Magnetic image, both breasts	1.63	24.51	NA	1.31	27.45	NA	XXX
76095	26	A	Stereotactic breast biopsy	1.59	0.52	0.52	0.09	2.20	2.20	XXX
76095	TC	A	Stereotactic breast biopsy	0.00	7.18	NA	0.37	7.55	NA	XXX
76095	.....	A	Stereotactic breast biopsy	1.59	7.70	NA	0.46	9.75	NA	XXX
76096	26	A	X-ray of needle wire, breast	0.56	0.18	0.18	0.02	0.76	0.76	XXX
76096	TC	A	X-ray of needle wire, breast	0.00	1.31	NA	0.07	1.38	NA	XXX
76096	.....	A	X-ray of needle wire, breast	0.56	1.49	NA	0.09	2.14	NA	XXX
76098	26	A	X-ray exam, breast specimen	0.16	0.05	0.05	0.01	0.22	0.22	XXX
76098	TC	A	X-ray exam, breast specimen	0.00	0.42	NA	0.02	0.44	NA	XXX
76098	.....	A	X-ray exam, breast specimen	0.16	0.47	NA	0.03	0.66	NA	XXX
76100	26	A	X-ray exam of body section	0.58	0.19	0.19	0.03	0.80	0.80	XXX
76100	TC	A	X-ray exam of body section	0.00	1.25	NA	0.07	1.32	NA	XXX
76100	.....	A	X-ray exam of body section	0.58	1.44	NA	0.10	2.12	NA	XXX
76101	26	A	Complex body section x-ray	0.58	0.19	0.19	0.03	0.80	0.80	XXX
76101	TC	A	Complex body section x-ray	0.00	1.42	NA	0.08	1.50	NA	XXX
76101	.....	A	Complex body section x-ray	0.58	1.61	NA	0.11	2.30	NA	XXX
76102	26	A	Complex body section x-rays	0.58	0.19	0.19	0.03	0.80	0.80	XXX
76102	TC	A	Complex body section x-rays	0.00	1.74	NA	0.11	1.85	NA	XXX
76102	.....	A	Complex body section x-rays	0.58	1.93	NA	0.14	2.65	NA	XXX
76120	26	A	Cine/video x-rays	0.38	0.13	0.13	0.02	0.53	0.53	XXX
76120	TC	A	Cine/video x-rays	0.00	1.05	NA	0.06	1.11	NA	XXX
76120	.....	A	Cine/video x-rays	0.38	1.18	NA	0.08	1.64	NA	XXX
76125	26	A	Cine/video x-rays add-on	0.27	0.09	0.09	0.01	0.37	0.37	ZZZ
76125	TC	A	Cine/video x-rays add-on	0.00	0.78	NA	0.05	0.83	NA	ZZZ
76125	.....	A	Cine/video x-rays add-on	0.27	0.87	NA	0.06	1.20	NA	ZZZ
76140	.....	I	X-ray consultation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76150	.....	A	X-ray exam, dry process	0.00	0.42	NA	0.02	0.44	NA	XXX
76350	.....	C	Special x-ray contrast study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76355	26	A	Ct scan for localization	1.21	0.40	0.40	0.05	1.66	1.66	XXX
76355	TC	A	Ct scan for localization	0.00	8.28	NA	0.42	8.70	NA	XXX
76355	.....	A	Ct scan for localization	1.21	8.68	NA	0.47	10.36	NA	XXX
76360	26	A	Ct scan for needle biopsy	1.16	0.38	0.38	0.05	1.59	1.59	XXX
76360	TC	A	Ct scan for needle biopsy	0.00	8.28	NA	0.42	8.70	NA	XXX
76360	.....	A	Ct scan for needle biopsy	1.16	8.66	NA	0.47	10.29	NA	XXX
76362	26	A	Ct guide for tissue ablation	3.99	1.30	1.30	0.18	5.47	5.47	XXX
76362	TC	A	Ct guide for tissue ablation	0.00	8.28	NA	1.46	9.74	NA	XXX
76362	.....	A	Ct guide for tissue ablation	3.99	9.58	NA	1.64	15.21	NA	XXX
76370	26	A	Ct scan for therapy guide	0.85	0.28	0.28	0.04	1.17	1.17	XXX
76370	TC	A	Ct scan for therapy guide	0.00	2.96	NA	0.16	3.12	NA	XXX
76370	.....	A	Ct scan for therapy guide	0.85	3.24	NA	0.20	4.29	NA	XXX
76376	26	A	3d render w/o postprocess	0.20	0.07	0.07	0.02	0.29	0.29	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
76376	TC	A	3d render w/o postprocess	0.00	3.43	NA	0.08	3.51	NA	XXX
76376	.....	A	3d render w/o postprocess	0.20	3.50	NA	0.10	3.80	NA	XXX
76377	26	A	3d rendering w/postprocess	0.79	0.27	0.27	0.08	1.14	1.14	XXX
76377	TC	A	3d rendering w/postprocess	0.00	3.43	NA	0.31	3.74	NA	XXX
76377	.....	A	3d rendering w/postprocess	0.79	3.70	NA	0.39	4.88	NA	XXX
76380	26	A	CAT scan follow-up study	0.98	0.32	0.32	0.04	1.34	1.34	XXX
76380	TC	A	CAT scan follow-up study	0.00	3.51	NA	0.18	3.69	NA	XXX
76380	.....	A	CAT scan follow-up study	0.98	3.83	NA	0.22	5.03	NA	XXX
76390	26	N	Mr spectroscopy	+1.40	0.47	0.47	0.07	1.94	1.94	XXX
76390	TC	N	Mr spectroscopy	+0.00	11.04	11.04	0.59	11.63	11.63	XXX
76390	.....	N	Mr spectroscopy	+1.40	11.51	11.51	0.66	13.57	13.57	XXX
76393	26	A	Mr guidance for needle place	1.50	0.50	0.50	0.09	2.09	2.09	XXX
76393	TC	A	Mr guidance for needle place	0.00	11.23	NA	0.55	11.78	NA	XXX
76393	.....	A	Mr guidance for needle place	1.50	11.73	NA	0.64	13.87	NA	XXX
76394	26	A	Mri for tissue ablation	4.24	1.38	1.38	0.24	5.86	5.86	XXX
76394	TC	A	Mri for tissue ablation	0.00	11.23	NA	1.57	12.80	NA	XXX
76394	.....	A	Mri for tissue ablation	4.24	12.61	NA	1.81	18.66	NA	XXX
76400	26	A	Magnetic image, bone marrow	1.60	0.52	0.52	0.07	2.19	2.19	XXX
76400	TC	A	Magnetic image, bone marrow	0.00	11.23	NA	0.59	11.82	NA	XXX
76400	.....	A	Magnetic image, bone marrow	1.60	11.75	NA	0.66	14.01	NA	XXX
76496	26	C	Fluoroscopic procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76496	TC	C	Fluoroscopic procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76496	.....	C	Fluoroscopic procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76497	26	C	Ct procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76497	TC	C	Ct procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76497	.....	C	Ct procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76498	26	C	Mri procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76498	TC	C	Mri procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76498	.....	C	Mri procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76499	26	C	Radiographic procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76499	TC	C	Radiographic procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76499	.....	C	Radiographic procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76506	26	A	Echo exam of head	0.63	0.24	0.24	0.06	0.93	0.93	XXX
76506	TC	A	Echo exam of head	0.00	1.42	NA	0.08	1.50	NA	XXX
76506	.....	A	Echo exam of head	0.63	1.66	NA	0.14	2.43	NA	XXX
76510	26	A	Ophth us, b & quant a	1.55	0.68	0.68	0.03	2.26	2.26	XXX
76510	TC	A	Ophth us, b & quant a	0.00	2.19	NA	0.07	2.26	NA	XXX
76510	.....	A	Ophth us, b & quant a	1.55	2.87	NA	0.10	4.52	NA	XXX
76511	26	A	Ophth us, quant a only	0.94	0.40	0.40	0.03	1.37	1.37	XXX
76511	TC	A	Ophth us, quant a only	0.00	2.04	NA	0.07	2.11	NA	XXX
76511	.....	A	Ophth us, quant a only	0.94	2.44	NA	0.10	3.48	NA	XXX
76512	26	A	Ophth us, b w/non-quant a	0.94	0.42	0.42	0.02	1.38	1.38	XXX
76512	TC	A	Ophth us, b w/non-quant a	0.00	1.82	NA	0.10	1.92	NA	XXX
76512	.....	A	Ophth us, b w/non-quant a	0.94	2.24	NA	0.12	3.30	NA	XXX
76513	26	A	Echo exam of eye, water bath	0.66	0.29	0.29	0.02	0.97	0.97	XXX
76513	TC	A	Echo exam of eye, water bath	0.00	1.52	NA	0.10	1.62	NA	XXX
76513	.....	A	Echo exam of eye, water bath	0.66	1.81	NA	0.12	2.59	NA	XXX
76514	26	A	Echo exam of eye, thickness	0.17	0.08	0.08	0.01	0.26	0.26	XXX
76514	TC	A	Echo exam of eye, thickness	0.00	0.05	NA	0.01	0.06	NA	XXX
76514	.....	A	Echo exam of eye, thickness	0.17	0.13	NA	0.02	0.32	NA	XXX
76516	26	A	Echo exam of eye	0.54	0.24	0.24	0.01	0.79	0.79	XXX
76516	TC	A	Echo exam of eye	0.00	1.22	NA	0.07	1.29	NA	XXX
76516	.....	A	Echo exam of eye	0.54	1.46	NA	0.08	2.08	NA	XXX
76519	26	A	Echo exam of eye	0.54	0.24	0.24	0.01	0.79	0.79	XXX
76519	TC	A	Echo exam of eye	0.00	1.31	NA	0.07	1.38	NA	XXX
76519	.....	A	Echo exam of eye	0.54	1.55	NA	0.08	2.17	NA	XXX
76529	26	A	Echo exam of eye	0.57	0.24	0.24	0.02	0.83	0.83	XXX
76529	TC	A	Echo exam of eye	0.00	1.13	NA	0.08	1.21	NA	XXX
76529	.....	A	Echo exam of eye	0.57	1.37	NA	0.10	2.04	NA	XXX
76536	26	A	Us exam of head and neck	0.56	0.18	0.18	0.02	0.76	0.76	XXX
76536	TC	A	Us exam of head and neck	0.00	1.42	NA	0.08	1.50	NA	XXX
76536	.....	A	Us exam of head and neck	0.56	1.60	NA	0.10	2.26	NA	XXX
76604	26	A	Us exam, chest, b-scan	0.55	0.18	0.18	0.02	0.75	0.75	XXX
76604	TC	A	Us exam, chest, b-scan	0.00	1.31	NA	0.07	1.38	NA	XXX
76604	.....	A	Us exam, chest, b-scan	0.55	1.49	NA	0.09	2.13	NA	XXX
76645	26	A	Us exam, breast(s)	0.54	0.18	0.18	0.02	0.74	0.74	XXX
76645	TC	A	Us exam, breast(s)	0.00	1.05	NA	0.06	1.11	NA	XXX
76645	.....	A	Us exam, breast(s)	0.54	1.23	NA	0.08	1.85	NA	XXX
76700	26	A	Us exam, abdom, complete	0.81	0.27	0.27	0.04	1.12	1.12	XXX
76700	TC	A	Us exam, abdom, complete	0.00	1.98	NA	0.11	2.09	NA	XXX
76700	.....	A	Us exam, abdom, complete	0.81	2.25	NA	0.15	3.21	NA	XXX
76705	26	A	Echo exam of abdomen	0.59	0.19	0.19	0.03	0.81	0.81	XXX
76705	TC	A	Echo exam of abdomen	0.00	1.42	NA	0.08	1.50	NA	XXX
76705	.....	A	Echo exam of abdomen	0.59	1.61	NA	0.11	2.31	NA	XXX
76770	26	A	Us exam abdo back wall, comp	0.74	0.24	0.24	0.03	1.01	1.01	XXX

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[3] +Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
76770	TC	A	Us exam abdo back wall, comp	0.00	1.98	NA	0.11	2.09	NA	XXX
76770	.....	A	Us exam abdo back wall, comp	0.74	2.22	NA	0.14	3.10	NA	XXX
76775	26	A	Us exam abdo back wall, lim	0.58	0.19	0.19	0.03	0.80	0.80	XXX
76775	TC	A	Us exam abdo back wall, lim	0.00	1.42	NA	0.08	1.50	NA	XXX
76775	.....	A	Us exam abdo back wall, lim	0.58	1.61	NA	0.11	2.30	NA	XXX
76778	26	A	Us exam kidney transplant	0.74	0.24	0.24	0.03	1.01	1.01	XXX
76778	TC	A	Us exam kidney transplant	0.00	1.98	NA	0.11	2.09	NA	XXX
76778	.....	A	Us exam kidney transplant	0.74	2.22	NA	0.14	3.10	NA	XXX
76800	26	A	Us exam, spinal canal	1.13	0.34	0.34	0.05	1.52	1.52	XXX
76800	TC	A	Us exam, spinal canal	0.00	1.42	NA	0.08	1.50	NA	XXX
76800	.....	A	Us exam, spinal canal	1.13	1.76	NA	0.13	3.02	NA	XXX
76801	26	A	Ob us < 14 wks, single fetus	0.99	0.34	0.34	0.04	1.37	1.37	XXX
76801	TC	A	Ob us < 14 wks, single fetus	0.00	2.11	NA	0.12	2.23	NA	XXX
76801	.....	A	Ob us < 14 wks, single fetus	0.99	2.45	NA	0.16	3.60	NA	XXX
76802	26	A	Ob us < 14 wks, add'l fetus	0.83	0.29	0.29	0.04	1.16	1.16	ZZZ
76802	TC	A	Ob us < 14 wks, add'l fetus	0.00	1.05	NA	0.12	1.17	NA	ZZZ
76802	.....	A	Ob us < 14 wks, add'l fetus	0.83	1.34	NA	0.16	2.33	NA	ZZZ
76805	26	A	Ob us >/= 14 wks, sngl fetus	0.99	0.34	0.34	0.04	1.37	1.37	XXX
76805	TC	A	Ob us >/= 14 wks, sngl fetus	0.00	2.11	NA	0.12	2.23	NA	XXX
76805	.....	A	Ob us >/= 14 wks, sngl fetus	0.99	2.45	NA	0.16	3.60	NA	XXX
76810	26	A	Ob us >/= 14 wks, addl fetus	0.98	0.34	0.34	0.04	1.36	1.36	ZZZ
76810	TC	A	Ob us >/= 14 wks, addl fetus	0.00	1.05	NA	0.22	1.27	NA	ZZZ
76810	.....	A	Ob us >/= 14 wks, addl fetus	0.98	1.39	NA	0.26	2.63	NA	ZZZ
76811	26	A	Ob us, detailed, sngl fetus	1.90	0.71	0.71	0.09	2.70	2.70	XXX
76811	TC	A	Ob us, detailed, sngl fetus	0.00	3.54	NA	0.43	3.97	NA	XXX
76811	.....	A	Ob us, detailed, sngl fetus	1.90	4.25	NA	0.52	6.67	NA	XXX
76812	26	A	Ob us, detailed, addl fetus	1.78	0.66	0.66	0.08	2.52	2.52	ZZZ
76812	TC	A	Ob us, detailed, addl fetus	0.00	1.05	NA	0.41	1.46	NA	ZZZ
76812	.....	A	Ob us, detailed, addl fetus	1.78	1.71	NA	0.49	3.98	NA	ZZZ
76815	26	A	Ob us, limited, fetus(s)	0.65	0.23	0.23	0.03	0.91	0.91	XXX
76815	TC	A	Ob us, limited, fetus(s)	0.00	1.42	NA	0.08	1.50	NA	XXX
76815	.....	A	Ob us, limited, fetus(s)	0.65	1.65	NA	0.11	2.41	NA	XXX
76816	26	A	Ob us, follow-up, per fetus	0.85	0.32	0.32	0.04	1.21	1.21	XXX
76816	TC	A	Ob us, follow-up, per fetus	0.00	1.11	NA	0.06	1.17	NA	XXX
76816	.....	A	Ob us, follow-up, per fetus	0.85	1.43	NA	0.10	2.38	NA	XXX
76817	26	A	Transvaginal us, obstetric	0.75	0.26	0.26	0.03	1.04	1.04	XXX
76817	TC	A	Transvaginal us, obstetric	0.00	1.52	NA	0.06	1.58	NA	XXX
76817	.....	A	Transvaginal us, obstetric	0.75	1.78	NA	0.09	2.62	NA	XXX
76818	26	A	Fetal biophys profile w/nst	1.05	0.39	0.39	0.05	1.49	1.49	XXX
76818	TC	A	Fetal biophys profile w/nst	0.00	1.61	NA	0.10	1.71	NA	XXX
76818	.....	A	Fetal biophys profile w/nst	1.05	2.00	NA	0.15	3.20	NA	XXX
76819	26	A	Fetal biophys profil w/o nst	0.77	0.28	0.28	0.03	1.08	1.08	XXX
76819	TC	A	Fetal biophys profil w/o nst	0.00	1.61	NA	0.10	1.71	NA	XXX
76819	.....	A	Fetal biophys profil w/o nst	0.77	1.89	NA	0.13	2.79	NA	XXX
76820	26	A	Umbilical artery echo	0.50	0.19	0.19	0.03	0.72	0.72	XXX
76820	TC	A	Umbilical artery echo	0.00	1.61	NA	0.12	1.73	NA	XXX
76820	.....	A	Umbilical artery echo	0.50	1.80	NA	0.15	2.45	NA	XXX
76821	26	A	Middle cerebral artery echo	0.70	0.27	0.27	0.03	1.00	1.00	XXX
76821	TC	A	Middle cerebral artery echo	0.00	1.61	NA	0.12	1.73	NA	XXX
76821	.....	A	Middle cerebral artery echo	0.70	1.88	NA	0.15	2.73	NA	XXX
76825	26	A	Echo exam of fetal heart	1.67	0.60	0.60	0.07	2.34	2.34	XXX
76825	TC	A	Echo exam of fetal heart	0.00	1.98	NA	0.11	2.09	NA	XXX
76825	.....	A	Echo exam of fetal heart	1.67	2.58	NA	0.18	4.43	NA	XXX
76826	26	A	Echo exam of fetal heart	0.83	0.29	0.29	0.03	1.15	1.15	XXX
76826	TC	A	Echo exam of fetal heart	0.00	0.71	NA	0.05	0.76	NA	XXX
76826	.....	A	Echo exam of fetal heart	0.83	1.00	NA	0.08	1.91	NA	XXX
76827	26	A	Echo exam of fetal heart	0.58	0.21	0.21	0.02	0.81	0.81	XXX
76827	TC	A	Echo exam of fetal heart	0.00	1.72	NA	0.12	1.84	NA	XXX
76827	.....	A	Echo exam of fetal heart	0.58	1.93	NA	0.14	2.65	NA	XXX
76828	26	A	Echo exam of fetal heart	0.56	0.22	0.22	0.03	0.81	0.81	XXX
76828	TC	A	Echo exam of fetal heart	0.00	1.11	NA	0.08	1.19	NA	XXX
76828	.....	A	Echo exam of fetal heart	0.56	1.33	NA	0.11	2.00	NA	XXX
76830	26	A	Transvaginal us, non-ob	0.69	0.23	0.23	0.03	0.95	0.95	XXX
76830	TC	A	Transvaginal us, non-ob	0.00	1.52	NA	0.10	1.62	NA	XXX
76830	.....	A	Transvaginal us, non-ob	0.69	1.75	NA	0.13	2.57	NA	XXX
76831	26	A	Echo exam, uterus	0.72	0.25	0.25	0.03	1.00	1.00	XXX
76831	TC	A	Echo exam, uterus	0.00	1.52	NA	0.10	1.62	NA	XXX
76831	.....	A	Echo exam, uterus	0.72	1.77	NA	0.13	2.62	NA	XXX
76856	26	A	Us exam, pelvic, complete	0.69	0.23	0.23	0.03	0.95	0.95	XXX
76856	TC	A	Us exam, pelvic, complete	0.00	1.52	NA	0.10	1.62	NA	XXX
76856	.....	A	Us exam, pelvic, complete	0.69	1.75	NA	0.13	2.57	NA	XXX
76857	26	A	Us exam, pelvic, limited	0.38	0.12	0.12	0.02	0.52	0.52	XXX
76857	TC	A	Us exam, pelvic, limited	0.00	1.71	NA	0.06	1.77	NA	XXX
76857	.....	A	Us exam, pelvic, limited	0.38	1.83	NA	0.08	2.29	NA	XXX
76870	26	A	Us exam, scrotum	0.64	0.21	0.21	0.03	0.88	0.88	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
76870	TC	A	Us exam, scrotum	0.00	1.52	NA	0.10	1.62	NA	XXX
76870	.....	A	Us exam, scrotum	0.64	1.73	NA	0.13	2.50	NA	XXX
76872	26	A	Us, transrectal	0.69	0.22	0.22	0.04	0.95	0.95	XXX
76872	TC	A	Us, transrectal	0.00	2.03	NA	0.10	2.13	NA	XXX
76872	.....	A	Us, transrectal	0.69	2.25	NA	0.14	3.08	NA	XXX
76873	26	A	Echograp trans r, pros study	1.55	0.50	0.50	0.09	2.14	2.14	XXX
76873	TC	A	Echograp trans r, pros study	0.00	2.11	NA	0.16	2.27	NA	XXX
76873	.....	A	Echograp trans r, pros study	1.55	2.61	NA	0.25	4.41	NA	XXX
76880	26	A	Us exam, extremity	0.59	0.19	0.19	0.03	0.81	0.81	XXX
76880	TC	A	Us exam, extremity	0.00	1.42	NA	0.08	1.50	NA	XXX
76880	.....	A	Us exam, extremity	0.59	1.61	NA	0.11	2.31	NA	XXX
76885	26	A	Us exam infant hips, dynamic	0.74	0.24	0.24	0.03	1.01	1.01	XXX
76885	TC	A	Us exam infant hips, dynamic	0.00	1.52	NA	0.10	1.62	NA	XXX
76885	.....	A	Us exam infant hips, dynamic	0.74	1.76	NA	0.13	2.63	NA	XXX
76886	26	A	Us exam infant hips, static	0.62	0.20	0.20	0.03	0.85	0.85	XXX
76886	TC	A	Us exam infant hips, static	0.00	1.42	NA	0.08	1.50	NA	XXX
76886	.....	A	Us exam infant hips, static	0.62	1.62	NA	0.11	2.35	NA	XXX
76930	26	A	Echo guide, cardiocentesis	0.67	0.25	0.25	0.02	0.94	0.94	XXX
76930	TC	A	Echo guide, cardiocentesis	0.00	1.52	NA	0.10	1.62	NA	XXX
76930	.....	A	Echo guide, cardiocentesis	0.67	1.77	NA	0.12	2.56	NA	XXX
76932	26	A	Echo guide for heart biopsy	0.67	0.25	0.25	0.02	0.94	0.94	XXX
76932	TC	A	Echo guide for heart biopsy	0.00	1.52	NA	0.10	1.62	NA	XXX
76932	.....	A	Echo guide for heart biopsy	0.67	1.77	NA	0.12	2.56	NA	XXX
76936	26	A	Echo guide for artery repair	1.99	0.66	0.66	0.13	2.78	2.78	XXX
76936	TC	A	Echo guide for artery repair	0.00	6.31	NA	0.34	6.65	NA	XXX
76936	.....	A	Echo guide for artery repair	1.99	6.97	NA	0.47	9.43	NA	XXX
76937	26	A	Us guide, vascular access	0.30	0.10	0.10	0.03	0.43	0.43	ZZZ
76937	TC	A	Us guide, vascular access	0.00	0.38	NA	0.10	0.48	NA	ZZZ
76937	.....	A	Us guide, vascular access	0.30	0.48	NA	0.13	0.91	NA	ZZZ
76940	26	A	Us guide, tissue ablation	2.00	0.65	0.65	0.31	2.96	2.96	XXX
76940	TC	A	Us guide, tissue ablation	0.00	1.52	NA	0.29	1.81	NA	XXX
76940	.....	A	Us guide, tissue ablation	2.00	2.17	NA	0.60	4.77	NA	XXX
76941	26	A	Echo guide for transfusion	1.34	0.47	0.47	0.07	1.88	1.88	XXX
76941	TC	A	Echo guide for transfusion	0.00	1.53	NA	0.08	1.61	NA	XXX
76941	.....	A	Echo guide for transfusion	1.34	2.00	NA	0.15	3.49	NA	XXX
76942	26	A	Echo guide for biopsy	0.67	0.22	0.22	0.03	0.92	0.92	XXX
76942	TC	A	Echo guide for biopsy	0.00	2.82	NA	0.10	2.92	NA	XXX
76942	.....	A	Echo guide for biopsy	0.67	3.04	NA	0.13	3.84	NA	XXX
76945	26	A	Echo guide, villus sampling	0.67	0.22	0.22	0.03	0.92	0.92	XXX
76945	TC	A	Echo guide, villus sampling	0.00	1.53	NA	0.08	1.61	NA	XXX
76945	.....	A	Echo guide, villus sampling	0.67	1.75	NA	0.11	2.53	NA	XXX
76946	26	A	Echo guide for amniocentesis	0.38	0.14	0.14	0.02	0.54	0.54	XXX
76946	TC	A	Echo guide for amniocentesis	0.00	1.52	NA	0.10	1.62	NA	XXX
76946	.....	A	Echo guide for amniocentesis	0.38	1.66	NA	0.12	2.16	NA	XXX
76948	26	A	Echo guide, ova aspiration	0.38	0.13	0.13	0.02	0.53	0.53	XXX
76948	TC	A	Echo guide, ova aspiration	0.00	1.52	NA	0.10	1.62	NA	XXX
76948	.....	A	Echo guide, ova aspiration	0.38	1.65	NA	0.12	2.15	NA	XXX
76950	26	A	Echo guidance radiotherapy	0.58	0.19	0.19	0.03	0.80	0.80	XXX
76950	TC	A	Echo guidance radiotherapy	0.00	1.31	NA	0.07	1.38	NA	XXX
76950	.....	A	Echo guidance radiotherapy	0.58	1.50	NA	0.10	2.18	NA	XXX
76965	26	A	Echo guidance radiotherapy	1.34	0.43	0.43	0.08	1.85	1.85	XXX
76965	TC	A	Echo guidance radiotherapy	0.00	5.59	NA	0.29	5.88	NA	XXX
76965	.....	A	Echo guidance radiotherapy	1.34	6.02	NA	0.37	7.73	NA	XXX
76970	26	A	Ultrasound exam follow-up	0.40	0.13	0.13	0.02	0.55	0.55	XXX
76970	TC	A	Ultrasound exam follow-up	0.00	1.05	NA	0.06	1.11	NA	XXX
76970	.....	A	Ultrasound exam follow-up	0.40	1.18	NA	0.08	1.66	NA	XXX
76975	26	A	GI endoscopic ultrasound	0.81	0.28	0.28	0.04	1.13	1.13	XXX
76975	TC	A	GI endoscopic ultrasound	0.00	1.52	NA	0.10	1.62	NA	XXX
76975	.....	A	GI endoscopic ultrasound	0.81	1.80	NA	0.14	2.75	NA	XXX
76977	26	A	Us bone density measure	0.05	0.02	0.02	0.01	0.08	0.08	XXX
76977	TC	A	Us bone density measure	0.00	0.82	NA	0.05	0.87	NA	XXX
76977	.....	A	Us bone density measure	0.05	0.84	NA	0.06	0.95	NA	XXX
76986	26	A	Ultrasound guide intraoper	1.20	0.40	0.40	0.13	1.73	1.73	XXX
76986	TC	A	Ultrasound guide intraoper	0.00	2.63	NA	0.14	2.77	NA	XXX
76986	.....	A	Ultrasound guide intraoper	1.20	3.03	NA	0.27	4.50	NA	XXX
76999	26	C	Echo examination procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76999	TC	C	Echo examination procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76999	.....	C	Echo examination procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77261	.....	A	Radiation therapy planning	1.39	0.51	0.51	0.07	1.97	1.97	XXX
77262	.....	A	Radiation therapy planning	2.11	0.75	0.75	0.11	2.97	2.97	XXX
77263	.....	A	Radiation therapy planning	3.14	1.11	1.11	0.16	4.41	4.41	XXX
77280	26	A	Set radiation therapy field	0.70	0.22	0.22	0.04	0.96	0.96	XXX
77280	TC	A	Set radiation therapy field	0.00	3.48	NA	0.18	3.66	NA	XXX
77280	.....	A	Set radiation therapy field	0.70	3.70	NA	0.22	4.62	NA	XXX
77285	26	A	Set radiation therapy field	1.05	0.34	0.34	0.05	1.44	1.44	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
77285	TC	A	Set radiation therapy field	0.00	5.59	NA	0.30	5.89	NA	XXX
77285		A	Set radiation therapy field	1.05	5.93	NA	0.35	7.33	NA	XXX
77290	26	A	Set radiation therapy field	1.56	0.50	0.50	0.08	2.14	2.14	XXX
77290	TC	A	Set radiation therapy field	0.00	6.53	NA	0.35	6.88	NA	XXX
77290		A	Set radiation therapy field	1.56	7.03	NA	0.43	9.02	NA	XXX
77295	26	A	Set radiation therapy field	4.56	1.46	1.46	0.23	6.25	6.25	XXX
77295	TC	A	Set radiation therapy field	0.00	28.01	NA	1.48	29.49	NA	XXX
77295		A	Set radiation therapy field	4.56	29.47	NA	1.71	35.74	NA	XXX
77299	26	C	Radiation therapy planning	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77299	TC	C	Radiation therapy planning	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77299		C	Radiation therapy planning	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77300	26	A	Radiation therapy dose plan	0.62	0.20	0.20	0.03	0.85	0.85	XXX
77300	TC	A	Radiation therapy dose plan	0.00	1.34	NA	0.07	1.41	NA	XXX
77300		A	Radiation therapy dose plan	0.62	1.54	NA	0.10	2.26	NA	XXX
77301	26	A	Radiotherapy dose plan, imrt	7.99	2.57	2.57	0.40	10.96	10.96	XXX
77301	TC	A	Radiotherapy dose plan, imrt	0.00	28.01	NA	1.48	29.49	NA	XXX
77301		A	Radiotherapy dose plan, imrt	7.99	30.58	NA	1.88	40.45	NA	XXX
77305	26	A	Teletx isodose plan simple	0.70	0.23	0.23	0.04	0.97	0.97	XXX
77305	TC	A	Teletx isodose plan simple	0.00	1.87	NA	0.11	1.98	NA	XXX
77305		A	Teletx isodose plan simple	0.70	2.10	NA	0.15	2.95	NA	XXX
77310	26	A	Teletx isodose plan intermed	1.05	0.34	0.34	0.05	1.44	1.44	XXX
77310	TC	A	Teletx isodose plan intermed	0.00	2.34	NA	0.13	2.47	NA	XXX
77310		A	Teletx isodose plan intermed	1.05	2.68	NA	0.18	3.91	NA	XXX
77315	26	A	Teletx isodose plan complex	1.56	0.50	0.50	0.08	2.14	2.14	XXX
77315	TC	A	Teletx isodose plan complex	0.00	2.67	NA	0.14	2.81	NA	XXX
77315		A	Teletx isodose plan complex	1.56	3.17	NA	0.22	4.95	NA	XXX
77321	26	A	Special teletx port plan	0.95	0.30	0.30	0.05	1.30	1.30	XXX
77321	TC	A	Special teletx port plan	0.00	4.05	NA	0.21	4.26	NA	XXX
77321		A	Special teletx port plan	0.95	4.35	NA	0.26	5.56	NA	XXX
77326	26	A	Brachytx isodose calc simp	0.93	0.30	0.30	0.05	1.28	1.28	XXX
77326	TC	A	Brachytx isodose calc simp	0.00	2.37	NA	0.13	2.50	NA	XXX
77326		A	Brachytx isodose calc simp	0.93	2.67	NA	0.18	3.78	NA	XXX
77327	26	A	Brachytx isodose calc interm	1.39	0.44	0.44	0.07	1.90	1.90	XXX
77327	TC	A	Brachytx isodose calc interm	0.00	3.48	NA	0.18	3.66	NA	XXX
77327		A	Brachytx isodose calc interm	1.39	3.92	NA	0.25	5.56	NA	XXX
77328	26	A	Brachytx isodose plan compl	2.09	0.67	0.67	0.11	2.87	2.87	XXX
77328	TC	A	Brachytx isodose plan compl	0.00	4.97	NA	0.25	5.22	NA	XXX
77328		A	Brachytx isodose plan compl	2.09	5.64	NA	0.36	8.09	NA	XXX
77331	26	A	Special radiation dosimetry	0.87	0.28	0.28	0.04	1.19	1.19	XXX
77331	TC	A	Special radiation dosimetry	0.00	0.50	NA	0.02	0.52	NA	XXX
77331		A	Special radiation dosimetry	0.87	0.78	NA	0.06	1.71	NA	XXX
77332	26	A	Radiation treatment aid(s)	0.54	0.17	0.17	0.03	0.74	0.74	XXX
77332	TC	A	Radiation treatment aid(s)	0.00	1.34	NA	0.07	1.41	NA	XXX
77332		A	Radiation treatment aid(s)	0.54	1.51	NA	0.10	2.15	NA	XXX
77333	26	A	Radiation treatment aid(s)	0.84	0.27	0.27	0.04	1.15	1.15	XXX
77333	TC	A	Radiation treatment aid(s)	0.00	1.90	NA	0.11	2.01	NA	XXX
77333		A	Radiation treatment aid(s)	0.84	2.17	NA	0.15	3.16	NA	XXX
77334	26	A	Radiation treatment aid(s)	1.24	0.40	0.40	0.06	1.70	1.70	XXX
77334	TC	A	Radiation treatment aid(s)	0.00	3.26	NA	0.17	3.43	NA	XXX
77334		A	Radiation treatment aid(s)	1.24	3.66	NA	0.23	5.13	NA	XXX
77336		A	Radiation physics consult	0.00	2.99	NA	0.16	3.15	NA	XXX
77370		A	Radiation physics consult	0.00	3.50	NA	0.18	3.68	NA	XXX
77399	26	C	External radiation dosimetry	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77399	TC	C	External radiation dosimetry	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77399		C	External radiation dosimetry	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77401		A	Radiation treatment delivery	0.00	1.78	NA	0.11	1.89	NA	XXX
77402		A	Radiation treatment delivery	0.00	1.78	NA	0.11	1.89	NA	XXX
77403		A	Radiation treatment delivery	0.00	1.78	NA	0.11	1.89	NA	XXX
77404		A	Radiation treatment delivery	0.00	1.78	NA	0.11	1.89	NA	XXX
77406		A	Radiation treatment delivery	0.00	1.78	NA	0.11	1.89	NA	XXX
77407		A	Radiation treatment delivery	0.00	2.10	NA	0.12	2.22	NA	XXX
77408		A	Radiation treatment delivery	0.00	2.10	NA	0.12	2.22	NA	XXX
77409		A	Radiation treatment delivery	0.00	2.10	NA	0.12	2.22	NA	XXX
77411		A	Radiation treatment delivery	0.00	2.10	NA	0.12	2.22	NA	XXX
77412		A	Radiation treatment delivery	0.00	2.34	NA	0.13	2.47	NA	XXX
77413		A	Radiation treatment delivery	0.00	2.34	NA	0.13	2.47	NA	XXX
77414		A	Radiation treatment delivery	0.00	2.34	NA	0.13	2.47	NA	XXX
77416		A	Radiation treatment delivery	0.00	2.34	NA	0.13	2.47	NA	XXX
77417		A	Radiology port film(s)	0.00	0.59	NA	0.04	0.63	NA	XXX
77418		A	Radiation tx delivery, imrt	0.00	18.07	NA	0.13	18.20	NA	XXX
77421	26	A	Stereoscopic x-ray guidance	0.39	0.13	0.13	0.02	0.54	0.54	XXX
77421	TC	A	Stereoscopic x-ray guidance	0.00	3.36	NA	0.10	3.46	NA	XXX
77421		A	Stereoscopic x-ray guidance	0.39	3.49	NA	0.12	4.00	NA	XXX
77422		A	Neutron beam tx, simple	0.00	1.71	NA	0.13	1.84	NA	XXX
77423		A	Neutron beam tx, complex	0.00	2.26	NA	0.13	2.39	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
77427	.....	A	Radiation tx management, x5	3.31	1.06	1.06	0.17	4.54	4.54	XXX
77431	.....	A	Radiation therapy management	1.81	0.68	0.68	0.09	2.58	2.58	XXX
77432	.....	A	Stereotactic radiation trmt	7.92	2.91	2.91	0.41	11.24	11.24	XXX
77470	26	A	Special radiation treatment	2.09	0.67	0.67	0.11	2.87	2.87	XXX
77470	TC	A	Special radiation treatment	0.00	11.18	NA	0.59	11.77	NA	XXX
77470	.....	A	Special radiation treatment	2.09	11.85	NA	0.70	14.64	NA	XXX
77499	26	C	Radiation therapy management	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77499	TC	C	Radiation therapy management	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77499	.....	C	Radiation therapy management	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77520	.....	C	Proton trmt, simple w/o comp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77522	.....	C	Proton trmt, simple w/comp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77523	.....	C	Proton trmt, intermediate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77525	.....	C	Proton treatment, complex	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77600	26	R	Hyperthermia treatment	1.56	0.50	0.50	0.08	2.14	2.14	XXX
77600	TC	R	Hyperthermia treatment	0.00	3.06	NA	0.16	3.22	NA	XXX
77600	.....	R	Hyperthermia treatment	1.56	3.56	NA	0.24	5.36	NA	XXX
77605	26	R	Hyperthermia treatment	2.09	0.66	0.66	0.16	2.91	2.91	XXX
77605	TC	R	Hyperthermia treatment	0.00	4.07	NA	0.22	4.29	NA	XXX
77605	.....	R	Hyperthermia treatment	2.09	4.73	NA	0.38	7.20	NA	XXX
77610	26	R	Hyperthermia treatment	1.56	0.51	0.51	0.08	2.15	2.15	XXX
77610	TC	R	Hyperthermia treatment	0.00	3.06	NA	0.16	3.22	NA	XXX
77610	.....	R	Hyperthermia treatment	1.56	3.57	NA	0.24	5.37	NA	XXX
77615	26	R	Hyperthermia treatment	2.09	0.66	0.66	0.11	2.86	2.86	XXX
77615	TC	R	Hyperthermia treatment	0.00	4.07	NA	0.22	4.29	NA	XXX
77615	.....	R	Hyperthermia treatment	2.09	4.73	NA	0.33	7.15	NA	XXX
77620	26	R	Hyperthermia treatment	1.56	0.52	0.52	0.20	2.28	2.28	XXX
77620	TC	R	Hyperthermia treatment	0.00	3.06	NA	0.16	3.22	NA	XXX
77620	.....	R	Hyperthermia treatment	1.56	3.58	NA	0.36	5.50	NA	XXX
77750	26	A	Infuse radioactive materials	4.90	1.58	1.58	0.25	6.73	6.73	090
77750	TC	A	Infuse radioactive materials	0.00	1.33	NA	0.07	1.40	NA	090
77750	.....	A	Infuse radioactive materials	4.90	2.91	NA	0.32	8.13	NA	090
77761	26	A	Apply intrcav radiat simple	3.80	1.09	1.09	0.19	5.08	5.08	090
77761	TC	A	Apply intrcav radiat simple	0.00	2.51	NA	0.14	2.65	NA	090
77761	.....	A	Apply intrcav radiat simple	3.80	3.60	NA	0.33	7.73	NA	090
77762	26	A	Apply intrcav radiat interm	5.71	1.84	1.84	0.29	7.84	7.84	090
77762	TC	A	Apply intrcav radiat interm	0.00	3.62	NA	0.19	3.81	NA	090
77762	.....	A	Apply intrcav radiat interm	5.71	5.46	NA	0.48	11.65	NA	090
77763	26	A	Apply intrcav radiat compl	8.56	2.75	2.75	0.43	11.74	11.74	090
77763	TC	A	Apply intrcav radiat compl	0.00	4.50	NA	0.23	4.73	NA	090
77763	.....	A	Apply intrcav radiat compl	8.56	7.25	NA	0.66	16.47	NA	090
77776	26	A	Apply interstit radiat simpl	4.65	0.95	0.95	0.44	6.04	6.04	090
77776	TC	A	Apply interstit radiat simpl	0.00	2.19	NA	0.13	2.32	NA	090
77776	.....	A	Apply interstit radiat simpl	4.65	3.14	NA	0.57	8.36	NA	090
77777	26	A	Apply interstit radiat inter	7.47	2.38	2.38	0.39	10.24	10.24	090
77777	TC	A	Apply interstit radiat inter	0.00	4.24	NA	0.22	4.46	NA	090
77777	.....	A	Apply interstit radiat inter	7.47	6.62	NA	0.61	14.70	NA	090
77778	26	A	Apply interstit radiat compl	11.17	3.58	3.58	0.57	15.32	15.32	090
77778	TC	A	Apply interstit radiat compl	0.00	5.14	NA	0.27	5.41	NA	090
77778	.....	A	Apply interstit radiat compl	11.17	8.72	NA	0.84	20.73	NA	090
77781	26	A	High intensity brachytherapy	1.66	0.53	0.53	0.08	2.27	2.27	090
77781	TC	A	High intensity brachytherapy	0.00	20.36	NA	1.06	21.42	NA	090
77781	.....	A	High intensity brachytherapy	1.66	20.89	NA	1.14	23.69	NA	090
77782	26	A	High intensity brachytherapy	2.49	0.80	0.80	0.13	3.42	3.42	090
77782	TC	A	High intensity brachytherapy	0.00	20.36	NA	1.06	21.42	NA	090
77782	.....	A	High intensity brachytherapy	2.49	21.16	NA	1.19	24.84	NA	090
77783	26	A	High intensity brachytherapy	3.72	1.19	1.19	0.19	5.10	5.10	090
77783	TC	A	High intensity brachytherapy	0.00	20.36	NA	1.06	21.42	NA	090
77783	.....	A	High intensity brachytherapy	3.72	21.55	NA	1.25	26.52	NA	090
77784	26	A	High intensity brachytherapy	5.60	1.80	1.80	0.29	7.69	7.69	090
77784	TC	A	High intensity brachytherapy	0.00	20.36	NA	1.06	21.42	NA	090
77784	.....	A	High intensity brachytherapy	5.60	22.16	NA	1.35	29.11	NA	090
77789	26	A	Apply surface radiation	1.12	0.37	0.37	0.06	1.55	1.55	000
77789	TC	A	Apply surface radiation	0.00	0.45	NA	0.02	0.47	NA	000
77789	.....	A	Apply surface radiation	1.12	0.82	NA	0.08	2.02	NA	000
77790	26	A	Radiation handling	1.05	0.34	0.34	0.05	1.44	1.44	XXX
77790	TC	A	Radiation handling	0.00	0.50	NA	0.02	0.52	NA	XXX
77790	.....	A	Radiation handling	1.05	0.84	NA	0.07	1.96	NA	XXX
77799	26	C	Radium/radioisotope therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77799	TC	C	Radium/radioisotope therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77799	.....	C	Radium/radioisotope therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78000	26	A	Thyroid, single uptake	0.19	0.06	0.06	0.01	0.26	0.26	XXX
78000	TC	A	Thyroid, single uptake	0.00	0.97	NA	0.06	1.03	NA	XXX
78000	.....	A	Thyroid, single uptake	0.19	1.03	NA	0.07	1.29	NA	XXX
78001	26	A	Thyroid, multiple uptakes	0.26	0.09	0.09	0.01	0.36	0.36	XXX
78001	TC	A	Thyroid, multiple uptakes	0.00	1.31	NA	0.07	1.38	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
78001	.....	A	Thyroid, multiple uptakes	0.26	1.40	NA	0.08	1.74	NA	XXX
78003	26	A	Thyroid suppress/stimul	0.33	0.11	0.11	0.01	0.45	0.45	XXX
78003	TC	A	Thyroid suppress/stimul	0.00	0.97	NA	0.06	1.03	NA	XXX
78003	.....	A	Thyroid suppress/stimul	0.33	1.08	NA	0.07	1.48	NA	XXX
78006	26	A	Thyroid imaging with uptake	0.49	0.16	0.16	0.02	0.67	0.67	XXX
78006	TC	A	Thyroid imaging with uptake	0.00	2.39	NA	0.13	2.52	NA	XXX
78006	.....	A	Thyroid imaging with uptake	0.49	2.55	NA	0.15	3.19	NA	XXX
78007	26	A	Thyroid image, mult uptakes	0.50	0.17	0.17	0.02	0.69	0.69	XXX
78007	TC	A	Thyroid image, mult uptakes	0.00	2.58	NA	0.14	2.72	NA	XXX
78007	.....	A	Thyroid image, mult uptakes	0.50	2.75	NA	0.16	3.41	NA	XXX
78010	26	A	Thyroid imaging	0.39	0.13	0.13	0.02	0.54	0.54	XXX
78010	TC	A	Thyroid imaging	0.00	1.83	NA	0.11	1.94	NA	XXX
78010	.....	A	Thyroid imaging	0.39	1.96	NA	0.13	2.48	NA	XXX
78011	26	A	Thyroid imaging with flow	0.45	0.15	0.15	0.02	0.62	0.62	XXX
78011	TC	A	Thyroid imaging with flow	0.00	2.42	NA	0.13	2.55	NA	XXX
78011	.....	A	Thyroid imaging with flow	0.45	2.57	NA	0.15	3.17	NA	XXX
78015	26	A	Thyroid met imaging	0.67	0.23	0.23	0.03	0.93	0.93	XXX
78015	TC	A	Thyroid met imaging	0.00	2.58	NA	0.14	2.72	NA	XXX
78015	.....	A	Thyroid met imaging	0.67	2.81	NA	0.17	3.65	NA	XXX
78016	26	A	Thyroid met imaging/studies	0.82	0.28	0.28	0.03	1.13	1.13	XXX
78016	TC	A	Thyroid met imaging/studies	0.00	3.49	NA	0.18	3.67	NA	XXX
78016	.....	A	Thyroid met imaging/studies	0.82	3.77	NA	0.21	4.80	NA	XXX
78018	26	A	Thyroid met imaging, body	0.86	0.30	0.30	0.04	1.20	1.20	XXX
78018	TC	A	Thyroid met imaging, body	0.00	5.44	NA	0.29	5.73	NA	XXX
78018	.....	A	Thyroid met imaging, body	0.86	5.74	NA	0.33	6.93	NA	XXX
78020	26	A	Thyroid met uptake	0.60	0.21	0.21	0.02	0.83	0.83	ZZZ
78020	TC	A	Thyroid met uptake	0.00	1.31	NA	0.14	1.45	NA	ZZZ
78020	.....	A	Thyroid met uptake	0.60	1.52	NA	0.16	2.28	NA	ZZZ
78070	26	A	Parathyroid nuclear imaging	0.82	0.28	0.28	0.04	1.14	1.14	XXX
78070	TC	A	Parathyroid nuclear imaging	0.00	4.28	NA	0.11	4.39	NA	XXX
78070	.....	A	Parathyroid nuclear imaging	0.82	4.56	NA	0.15	5.53	NA	XXX
78075	26	A	Adrenal nuclear imaging	0.74	0.26	0.26	0.03	1.03	1.03	XXX
78075	TC	A	Adrenal nuclear imaging	0.00	5.44	NA	0.29	5.73	NA	XXX
78075	.....	A	Adrenal nuclear imaging	0.74	5.70	NA	0.32	6.76	NA	XXX
78099	26	C	Endocrine nuclear procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78099	TC	C	Endocrine nuclear procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78099	.....	C	Endocrine nuclear procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78102	26	A	Bone marrow imaging, ltd	0.55	0.19	0.19	0.02	0.76	0.76	XXX
78102	TC	A	Bone marrow imaging, ltd	0.00	2.05	NA	0.12	2.17	NA	XXX
78102	.....	A	Bone marrow imaging, ltd	0.55	2.24	NA	0.14	2.93	NA	XXX
78103	26	A	Bone marrow imaging, mult	0.75	0.26	0.26	0.03	1.04	1.04	XXX
78103	TC	A	Bone marrow imaging, mult	0.00	3.18	NA	0.17	3.35	NA	XXX
78103	.....	A	Bone marrow imaging, mult	0.75	3.44	NA	0.20	4.39	NA	XXX
78104	26	A	Bone marrow imaging, body	0.80	0.27	0.27	0.03	1.10	1.10	XXX
78104	TC	A	Bone marrow imaging, body	0.00	4.08	NA	0.22	4.30	NA	XXX
78104	.....	A	Bone marrow imaging, body	0.80	4.35	NA	0.25	5.40	NA	XXX
78110	26	A	Plasma volume, single	0.19	0.07	0.07	0.01	0.27	0.27	XXX
78110	TC	A	Plasma volume, single	0.00	0.95	NA	0.06	1.01	NA	XXX
78110	.....	A	Plasma volume, single	0.19	1.02	NA	0.07	1.28	NA	XXX
78111	26	A	Plasma volume, multiple	0.22	0.08	0.08	0.01	0.31	0.31	XXX
78111	TC	A	Plasma volume, multiple	0.00	2.58	NA	0.14	2.72	NA	XXX
78111	.....	A	Plasma volume, multiple	0.22	2.66	NA	0.15	3.03	NA	XXX
78120	26	A	Red cell mass, single	0.23	0.08	0.08	0.01	0.32	0.32	XXX
78120	TC	A	Red cell mass, single	0.00	1.74	NA	0.11	1.85	NA	XXX
78120	.....	A	Red cell mass, single	0.23	1.82	NA	0.12	2.17	NA	XXX
78121	26	A	Red cell mass, multiple	0.32	0.11	0.11	0.01	0.44	0.44	XXX
78121	TC	A	Red cell mass, multiple	0.00	2.92	NA	0.14	3.06	NA	XXX
78121	.....	A	Red cell mass, multiple	0.32	3.03	NA	0.15	3.50	NA	XXX
78122	26	A	Blood volume	0.45	0.16	0.16	0.02	0.63	0.63	XXX
78122	TC	A	Blood volume	0.00	4.61	NA	0.24	4.85	NA	XXX
78122	.....	A	Blood volume	0.45	4.77	NA	0.26	5.48	NA	XXX
78130	26	A	Red cell survival study	0.61	0.21	0.21	0.03	0.85	0.85	XXX
78130	TC	A	Red cell survival study	0.00	2.86	NA	0.14	3.00	NA	XXX
78130	.....	A	Red cell survival study	0.61	3.07	NA	0.17	3.85	NA	XXX
78135	26	A	Red cell survival kinetics	0.64	0.22	0.22	0.03	0.89	0.89	XXX
78135	TC	A	Red cell survival kinetics	0.00	4.88	NA	0.25	5.13	NA	XXX
78135	.....	A	Red cell survival kinetics	0.64	5.10	NA	0.28	6.02	NA	XXX
78140	26	A	Red cell sequestration	0.61	0.20	0.20	0.03	0.84	0.84	XXX
78140	TC	A	Red cell sequestration	0.00	3.94	NA	0.21	4.15	NA	XXX
78140	.....	A	Red cell sequestration	0.61	4.14	NA	0.24	4.99	NA	XXX
78185	26	A	Spleen imaging	0.40	0.14	0.14	0.02	0.56	0.56	XXX
78185	TC	A	Spleen imaging	0.00	2.37	NA	0.13	2.50	NA	XXX
78185	.....	A	Spleen imaging	0.40	2.51	NA	0.15	3.06	NA	XXX
78190	26	A	Platelet survival, kinetics	1.09	0.39	0.39	0.08	1.56	1.56	XXX
78190	TC	A	Platelet survival, kinetics	0.00	5.73	NA	0.30	6.03	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
78190	.....	A	Platelet survival, kinetics	1.09	6.12	NA	0.38	7.59	NA	XXX
78191	26	A	Platelet survival	0.61	0.20	0.20	0.03	0.84	0.84	XXX
78191	TC	A	Platelet survival	0.00	7.36	NA	0.37	7.73	NA	XXX
78191	.....	A	Platelet survival	0.61	7.56	NA	0.40	8.57	NA	XXX
78195	26	A	Lymph system imaging	1.20	0.41	0.41	0.06	1.67	1.67	XXX
78195	TC	A	Lymph system imaging	0.00	4.08	NA	0.22	4.30	NA	XXX
78195	.....	A	Lymph system imaging	1.20	4.49	NA	0.28	5.97	NA	XXX
78199	26	C	Blood/lymph nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78199	TC	C	Blood/lymph nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78199	.....	C	Blood/lymph nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78201	26	A	Liver imaging	0.44	0.15	0.15	0.02	0.61	0.61	XXX
78201	TC	A	Liver imaging	0.00	2.37	NA	0.13	2.50	NA	XXX
78201	.....	A	Liver imaging	0.44	2.52	NA	0.15	3.11	NA	XXX
78202	26	A	Liver imaging with flow	0.51	0.17	0.17	0.02	0.70	0.70	XXX
78202	TC	A	Liver imaging with flow	0.00	2.89	NA	0.14	3.03	NA	XXX
78202	.....	A	Liver imaging with flow	0.51	3.06	NA	0.16	3.73	NA	XXX
78205	26	A	Liver imaging (3D)	0.71	0.24	0.24	0.03	0.98	0.98	XXX
78205	TC	A	Liver imaging (3D)	0.00	5.93	NA	0.31	6.24	NA	XXX
78205	.....	A	Liver imaging (3D)	0.71	6.17	NA	0.34	7.22	NA	XXX
78206	26	A	Liver image (3d) with flow	0.96	0.33	0.33	0.04	1.33	1.33	XXX
78206	TC	A	Liver image (3d) with flow	0.00	5.93	NA	0.11	6.04	NA	XXX
78206	.....	A	Liver image (3d) with flow	0.96	6.26	NA	0.15	7.37	NA	XXX
78215	26	A	Liver and spleen imaging	0.49	0.16	0.16	0.02	0.67	0.67	XXX
78215	TC	A	Liver and spleen imaging	0.00	2.95	NA	0.14	3.09	NA	XXX
78215	.....	A	Liver and spleen imaging	0.49	3.11	NA	0.16	3.76	NA	XXX
78216	26	A	Liver & spleen image/flow	0.57	0.19	0.19	0.02	0.78	0.78	XXX
78216	TC	A	Liver & spleen image/flow	0.00	3.49	NA	0.18	3.67	NA	XXX
78216	.....	A	Liver & spleen image/flow	0.57	3.68	NA	0.20	4.45	NA	XXX
78220	26	A	Liver function study	0.49	0.16	0.16	0.02	0.67	0.67	XXX
78220	TC	A	Liver function study	0.00	3.73	NA	0.19	3.92	NA	XXX
78220	.....	A	Liver function study	0.49	3.89	NA	0.21	4.59	NA	XXX
78223	26	A	Hepatobiliary imaging	0.84	0.28	0.28	0.04	1.16	1.16	XXX
78223	TC	A	Hepatobiliary imaging	0.00	3.67	NA	0.19	3.86	NA	XXX
78223	.....	A	Hepatobiliary imaging	0.84	3.95	NA	0.23	5.02	NA	XXX
78230	26	A	Salivary gland imaging	0.45	0.15	0.15	0.02	0.62	0.62	XXX
78230	TC	A	Salivary gland imaging	0.00	2.19	NA	0.13	2.32	NA	XXX
78230	.....	A	Salivary gland imaging	0.45	2.34	NA	0.15	2.94	NA	XXX
78231	26	A	Serial salivary imaging	0.52	0.18	0.18	0.02	0.72	0.72	XXX
78231	TC	A	Serial salivary imaging	0.00	3.18	NA	0.17	3.35	NA	XXX
78231	.....	A	Serial salivary imaging	0.52	3.36	NA	0.19	4.07	NA	XXX
78232	26	A	Salivary gland function exam	0.47	0.16	0.16	0.02	0.65	0.65	XXX
78232	TC	A	Salivary gland function exam	0.00	3.55	NA	0.18	3.73	NA	XXX
78232	.....	A	Salivary gland function exam	0.47	3.71	NA	0.20	4.38	NA	XXX
78258	26	A	Esophageal motility study	0.74	0.25	0.25	0.03	1.02	1.02	XXX
78258	TC	A	Esophageal motility study	0.00	2.89	NA	0.14	3.03	NA	XXX
78258	.....	A	Esophageal motility study	0.74	3.14	NA	0.17	4.05	NA	XXX
78261	26	A	Gastric mucosa imaging	0.69	0.24	0.24	0.03	0.96	0.96	XXX
78261	TC	A	Gastric mucosa imaging	0.00	4.11	NA	0.22	4.33	NA	XXX
78261	.....	A	Gastric mucosa imaging	0.69	4.35	NA	0.25	5.29	NA	XXX
78262	26	A	Gastroesophageal reflux exam	0.68	0.23	0.23	0.03	0.94	0.94	XXX
78262	TC	A	Gastroesophageal reflux exam	0.00	4.26	NA	0.22	4.48	NA	XXX
78262	.....	A	Gastroesophageal reflux exam	0.68	4.49	NA	0.25	5.42	NA	XXX
78264	26	A	Gastric emptying study	0.78	0.26	0.26	0.03	1.07	1.07	XXX
78264	TC	A	Gastric emptying study	0.00	4.14	NA	0.22	4.36	NA	XXX
78264	.....	A	Gastric emptying study	0.78	4.40	NA	0.25	5.43	NA	XXX
78267	.....	X	Breath tst attain/anal c-14	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78268	.....	X	Breath test analysis, c-14	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78270	26	A	Vit B-12 absorption exam	0.20	0.07	0.07	0.01	0.28	0.28	XXX
78270	TC	A	Vit B-12 absorption exam	0.00	1.55	NA	0.10	1.65	NA	XXX
78270	.....	A	Vit B-12 absorption exam	0.20	1.62	NA	0.11	1.93	NA	XXX
78271	26	A	Vit b-12 absrp exam, int fac	0.20	0.07	0.07	0.01	0.28	0.28	XXX
78271	TC	A	Vit b-12 absrp exam, int fac	0.00	1.64	NA	0.10	1.74	NA	XXX
78271	.....	A	Vit b-12 absrp exam, int fac	0.20	1.71	NA	0.11	2.02	NA	XXX
78272	26	A	Vit B-12 absorp, combined	0.27	0.09	0.09	0.01	0.37	0.37	XXX
78272	TC	A	Vit B-12 absorp, combined	0.00	2.33	NA	0.13	2.46	NA	XXX
78272	.....	A	Vit B-12 absorp, combined	0.27	2.42	NA	0.14	2.83	NA	XXX
78278	26	A	Acute GI blood loss imaging	0.99	0.33	0.33	0.04	1.36	1.36	XXX
78278	TC	A	Acute GI blood loss imaging	0.00	4.88	NA	0.25	5.13	NA	XXX
78278	.....	A	Acute GI blood loss imaging	0.99	5.21	NA	0.29	6.49	NA	XXX
78282	26	A	GI protein loss exam	0.38	0.13	0.13	0.02	0.53	0.53	XXX
78282	TC	C	GI protein loss exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78282	.....	C	GI protein loss exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78290	26	A	Meckel's divert exam	0.68	0.23	0.23	0.03	0.94	0.94	XXX
78290	TC	A	Meckel's divert exam	0.00	3.06	NA	0.16	3.22	NA	XXX
78290	.....	A	Meckel's divert exam	0.68	3.29	NA	0.19	4.16	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
78291	26	A	Leveen/shunt patency exam	0.88	0.30	0.30	0.04	1.22	1.22	XXX
78291	TC	A	Leveen/shunt patency exam	0.00	3.07	NA	0.16	3.23	NA	XXX
78291	.....	A	Leveen/shunt patency exam	0.88	3.37	NA	0.20	4.45	NA	XXX
78299	26	C	GI nuclear procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78299	TC	C	GI nuclear procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78299	.....	C	GI nuclear procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78300	26	A	Bone imaging, limited area	0.62	0.21	0.21	0.03	0.86	0.86	XXX
78300	TC	A	Bone imaging, limited area	0.00	2.49	NA	0.14	2.63	NA	XXX
78300	.....	A	Bone imaging, limited area	0.62	2.70	NA	0.17	3.49	NA	XXX
78305	26	A	Bone imaging, multiple areas	0.83	0.28	0.28	0.04	1.15	1.15	XXX
78305	TC	A	Bone imaging, multiple areas	0.00	3.67	NA	0.19	3.86	NA	XXX
78305	.....	A	Bone imaging, multiple areas	0.83	3.95	NA	0.23	5.01	NA	XXX
78306	26	A	Bone imaging, whole body	0.86	0.29	0.29	0.04	1.19	1.19	XXX
78306	TC	A	Bone imaging, whole body	0.00	4.28	NA	0.22	4.50	NA	XXX
78306	.....	A	Bone imaging, whole body	0.86	4.57	NA	0.26	5.69	NA	XXX
78315	26	A	Bone imaging, 3 phase	1.02	0.34	0.34	0.04	1.40	1.40	XXX
78315	TC	A	Bone imaging, 3 phase	0.00	4.79	NA	0.25	5.04	NA	XXX
78315	.....	A	Bone imaging, 3 phase	1.02	5.13	NA	0.29	6.44	NA	XXX
78320	26	A	Bone imaging (3D)	1.04	0.36	0.36	0.04	1.44	1.44	XXX
78320	TC	A	Bone imaging (3D)	0.00	5.93	NA	0.31	6.24	NA	XXX
78320	.....	A	Bone imaging (3D)	1.04	6.29	NA	0.35	7.68	NA	XXX
78350	26	A	Bone mineral, single photon	0.22	0.07	0.07	0.01	0.30	0.30	XXX
78350	TC	A	Bone mineral, single photon	0.00	0.75	NA	0.05	0.80	NA	XXX
78350	.....	A	Bone mineral, single photon	0.22	0.82	NA	0.06	1.10	NA	XXX
78351	.....	N	Bone mineral, dual photon	+0.30	1.72	0.12	0.01	2.03	0.43	XXX
78399	26	C	Musculoskeletal nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78399	TC	C	Musculoskeletal nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78399	.....	C	Musculoskeletal nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78414	26	A	Non-imaging heart function	0.45	0.16	0.16	0.02	0.63	0.63	XXX
78414	TC	C	Non-imaging heart function	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78414	.....	C	Non-imaging heart function	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78428	26	A	Cardiac shunt imaging	0.78	0.29	0.29	0.03	1.10	1.10	XXX
78428	TC	A	Cardiac shunt imaging	0.00	2.26	NA	0.13	2.39	NA	XXX
78428	.....	A	Cardiac shunt imaging	0.78	2.55	NA	0.16	3.49	NA	XXX
78445	26	A	Vascular flow imaging	0.49	0.17	0.17	0.02	0.68	0.68	XXX
78445	TC	A	Vascular flow imaging	0.00	1.87	NA	0.11	1.98	NA	XXX
78445	.....	A	Vascular flow imaging	0.49	2.04	NA	0.13	2.66	NA	XXX
78456	26	A	Acute venous thrombus image	1.00	0.34	0.34	0.04	1.38	1.38	XXX
78456	TC	A	Acute venous thrombus image	0.00	3.99	NA	0.29	4.28	NA	XXX
78456	.....	A	Acute venous thrombus image	1.00	4.33	NA	0.33	5.66	NA	XXX
78457	26	A	Venous thrombosis imaging	0.77	0.26	0.26	0.03	1.06	1.06	XXX
78457	TC	A	Venous thrombosis imaging	0.00	2.67	NA	0.14	2.81	NA	XXX
78457	.....	A	Venous thrombosis imaging	0.77	2.93	NA	0.17	3.87	NA	XXX
78458	26	A	Ven thrombosis images, bilat	0.90	0.32	0.32	0.04	1.26	1.26	XXX
78458	TC	A	Ven thrombosis images, bilat	0.00	4.03	NA	0.21	4.24	NA	XXX
78458	.....	A	Ven thrombosis images, bilat	0.90	4.35	NA	0.25	5.50	NA	XXX
78459	26	A	Heart muscle imaging (PET)	1.50	0.57	0.57	0.05	2.12	2.12	XXX
78459	TC	C	Heart muscle imaging (PET)	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78459	.....	C	Heart muscle imaging (PET)	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78460	26	A	Heart muscle blood, single	0.86	0.29	0.29	0.04	1.19	1.19	XXX
78460	TC	A	Heart muscle blood, single	0.00	2.37	NA	0.13	2.50	NA	XXX
78460	.....	A	Heart muscle blood, single	0.86	2.66	NA	0.17	3.69	NA	XXX
78461	26	A	Heart muscle blood, multiple	1.23	0.43	0.43	0.05	1.71	1.71	XXX
78461	TC	A	Heart muscle blood, multiple	0.00	4.73	NA	0.25	4.98	NA	XXX
78461	.....	A	Heart muscle blood, multiple	1.23	5.16	NA	0.30	6.69	NA	XXX
78464	26	A	Heart image (3d), single	1.09	0.38	0.38	0.04	1.51	1.51	XXX
78464	TC	A	Heart image (3d), single	0.00	7.09	NA	0.37	7.46	NA	XXX
78464	.....	A	Heart image (3d), single	1.09	7.47	NA	0.41	8.97	NA	XXX
78465	26	A	Heart image (3d), multiple	1.46	0.52	0.52	0.05	2.03	2.03	XXX
78465	TC	A	Heart image (3d), multiple	0.00	11.82	NA	0.62	12.44	NA	XXX
78465	.....	A	Heart image (3d), multiple	1.46	12.34	NA	0.67	14.47	NA	XXX
78466	26	A	Heart infarct image	0.69	0.24	0.24	0.03	0.96	0.96	XXX
78466	TC	A	Heart infarct image	0.00	2.63	NA	0.14	2.77	NA	XXX
78466	.....	A	Heart infarct image	0.69	2.87	NA	0.17	3.73	NA	XXX
78468	26	A	Heart infarct image (ef)	0.80	0.27	0.27	0.03	1.10	1.10	XXX
78468	TC	A	Heart infarct image (ef)	0.00	3.67	NA	0.19	3.86	NA	XXX
78468	.....	A	Heart infarct image (ef)	0.80	3.94	NA	0.22	4.96	NA	XXX
78469	26	A	Heart infarct image (3D)	0.92	0.31	0.31	0.03	1.26	1.26	XXX
78469	TC	A	Heart infarct image (3D)	0.00	5.24	NA	0.28	5.52	NA	XXX
78469	.....	A	Heart infarct image (3D)	0.92	5.55	NA	0.31	6.78	NA	XXX
78472	26	A	Gated heart, planar, single	0.98	0.34	0.34	0.04	1.36	1.36	XXX
78472	TC	A	Gated heart, planar, single	0.00	5.53	NA	0.30	5.83	NA	XXX
78472	.....	A	Gated heart, planar, single	0.98	5.87	NA	0.34	7.19	NA	XXX
78473	26	A	Gated heart, multiple	1.47	0.51	0.51	0.06	2.04	2.04	XXX
78473	TC	A	Gated heart, multiple	0.00	8.28	NA	0.42	8.70	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
78473	.....	A	Gated heart, multiple	1.47	8.79	NA	0.48	10.74	NA	XXX
78478	26	A	Heart wall motion add-on	0.62	0.23	0.23	0.02	0.87	0.87	XXX
78478	TC	A	Heart wall motion add-on	0.00	1.56	NA	0.10	1.66	NA	XXX
78478	.....	A	Heart wall motion add-on	0.62	1.79	NA	0.12	2.53	NA	XXX
78480	26	A	Heart function add-on	0.62	0.22	0.22	0.02	0.86	0.86	XXX
78480	TC	A	Heart function add-on	0.00	1.56	NA	0.10	1.66	NA	XXX
78480	.....	A	Heart function add-on	0.62	1.78	NA	0.12	2.52	NA	XXX
78481	26	A	Heart first pass, single	0.98	0.36	0.36	0.03	1.37	1.37	XXX
78481	TC	A	Heart first pass, single	0.00	5.24	NA	0.28	5.52	NA	XXX
78481	.....	A	Heart first pass, single	0.98	5.60	NA	0.31	6.89	NA	XXX
78483	26	A	Heart first pass, multiple	1.47	0.54	0.54	0.05	2.06	2.06	XXX
78483	TC	A	Heart first pass, multiple	0.00	7.89	NA	0.41	8.30	NA	XXX
78483	.....	A	Heart first pass, multiple	1.47	8.43	NA	0.46	10.36	NA	XXX
78491	26	A	Heart image (pet), single	1.50	0.59	0.59	0.06	2.15	2.15	XXX
78491	TC	C	Heart image (pet), single	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78491	.....	C	Heart image (pet), single	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78492	26	A	Heart image (pet), multiple	1.87	0.74	0.74	0.07	2.68	2.68	XXX
78492	TC	C	Heart image (pet), multiple	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78492	.....	C	Heart image (pet), multiple	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78494	26	A	Heart image, spect	1.19	0.42	0.42	0.05	1.66	1.66	XXX
78494	TC	A	Heart image, spect	0.00	7.09	NA	0.30	7.39	NA	XXX
78494	.....	A	Heart image, spect	1.19	7.51	NA	0.35	9.05	NA	XXX
78496	26	A	Heart first pass add-on	0.50	0.18	0.18	0.02	0.70	0.70	ZZZ
78496	TC	A	Heart first pass add-on	0.00	7.09	NA	0.30	7.39	NA	ZZZ
78496	.....	A	Heart first pass add-on	0.50	7.27	NA	0.32	8.09	NA	ZZZ
78499	26	C	Cardiovascular nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78499	TC	C	Cardiovascular nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78499	.....	C	Cardiovascular nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78580	26	A	Lung perfusion imaging	0.74	0.25	0.25	0.03	1.02	1.02	XXX
78580	TC	A	Lung perfusion imaging	0.00	3.44	NA	0.18	3.62	NA	XXX
78580	.....	A	Lung perfusion imaging	0.74	3.69	NA	0.21	4.64	NA	XXX
78584	26	A	Lung V/Q image single breath	0.99	0.33	0.33	0.04	1.36	1.36	XXX
78584	TC	A	Lung V/Q image single breath	0.00	3.21	NA	0.17	3.38	NA	XXX
78584	.....	A	Lung V/Q image single breath	0.99	3.54	NA	0.21	4.74	NA	XXX
78585	26	A	Lung V/Q imaging	1.09	0.36	0.36	0.05	1.50	1.50	XXX
78585	TC	A	Lung V/Q imaging	0.00	5.66	NA	0.30	5.96	NA	XXX
78585	.....	A	Lung V/Q imaging	1.09	6.02	NA	0.35	7.46	NA	XXX
78586	26	A	Aerosol lung image, single	0.40	0.13	0.13	0.02	0.55	0.55	XXX
78586	TC	A	Aerosol lung image, single	0.00	2.60	NA	0.14	2.74	NA	XXX
78586	.....	A	Aerosol lung image, single	0.40	2.73	NA	0.16	3.29	NA	XXX
78587	26	A	Aerosol lung image, multiple	0.49	0.17	0.17	0.02	0.68	0.68	XXX
78587	TC	A	Aerosol lung image, multiple	0.00	2.81	NA	0.14	2.95	NA	XXX
78587	.....	A	Aerosol lung image, multiple	0.49	2.98	NA	0.16	3.63	NA	XXX
78588	26	A	Perfusion lung image	1.09	0.36	0.36	0.05	1.50	1.50	XXX
78588	TC	A	Perfusion lung image	0.00	3.21	NA	0.18	3.39	NA	XXX
78588	.....	A	Perfusion lung image	1.09	3.57	NA	0.23	4.89	NA	XXX
78591	26	A	Vent image, 1 breath, 1 proj	0.40	0.13	0.13	0.02	0.55	0.55	XXX
78591	TC	A	Vent image, 1 breath, 1 proj	0.00	2.86	NA	0.14	3.00	NA	XXX
78591	.....	A	Vent image, 1 breath, 1 proj	0.40	2.99	NA	0.16	3.55	NA	XXX
78593	26	A	Vent image, 1 proj, gas	0.49	0.16	0.16	0.02	0.67	0.67	XXX
78593	TC	A	Vent image, 1 proj, gas	0.00	3.46	NA	0.18	3.64	NA	XXX
78593	.....	A	Vent image, 1 proj, gas	0.49	3.62	NA	0.20	4.31	NA	XXX
78594	26	A	Vent image, mult proj, gas	0.53	0.18	0.18	0.02	0.73	0.73	XXX
78594	TC	A	Vent image, mult proj, gas	0.00	4.99	NA	0.25	5.24	NA	XXX
78594	.....	A	Vent image, mult proj, gas	0.53	5.17	NA	0.27	5.97	NA	XXX
78596	26	A	Lung differential function	1.27	0.42	0.42	0.05	1.74	1.74	XXX
78596	TC	A	Lung differential function	0.00	7.09	NA	0.37	7.46	NA	XXX
78596	.....	A	Lung differential function	1.27	7.51	NA	0.42	9.20	NA	XXX
78599	26	C	Respiratory nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78599	TC	C	Respiratory nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78599	.....	C	Respiratory nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78600	26	A	Brain imaging, ltd static	0.44	0.15	0.15	0.02	0.61	0.61	XXX
78600	TC	A	Brain imaging, ltd static	0.00	2.89	NA	0.14	3.03	NA	XXX
78600	.....	A	Brain imaging, ltd static	0.44	3.04	NA	0.16	3.64	NA	XXX
78601	26	A	Brain imaging, ltd w/flow	0.51	0.17	0.17	0.02	0.70	0.70	XXX
78601	TC	A	Brain imaging, ltd w/flow	0.00	3.41	NA	0.18	3.59	NA	XXX
78601	.....	A	Brain imaging, ltd w/flow	0.51	3.58	NA	0.20	4.29	NA	XXX
78605	26	A	Brain imaging, complete	0.53	0.18	0.18	0.02	0.73	0.73	XXX
78605	TC	A	Brain imaging, complete	0.00	3.41	NA	0.18	3.59	NA	XXX
78605	.....	A	Brain imaging, complete	0.53	3.59	NA	0.20	4.32	NA	XXX
78606	26	A	Brain imaging, compl w/flow	0.64	0.21	0.21	0.03	0.88	0.88	XXX
78606	TC	A	Brain imaging, compl w/flow	0.00	3.88	NA	0.21	4.09	NA	XXX
78606	.....	A	Brain imaging, compl w/flow	0.64	4.09	NA	0.24	4.97	NA	XXX
78607	26	A	Brain imaging (3D)	1.23	0.43	0.43	0.05	1.71	1.71	XXX
78607	TC	A	Brain imaging (3D)	0.00	6.57	NA	0.35	6.92	NA	XXX

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[3] +Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
78607	.....	A	Brain imaging (3D)	1.23	7.00	NA	0.40	8.63	NA	XXX
78608	26	A	Brain imaging (PET)	1.50	0.51	0.51	0.06	2.07	2.07	XXX
78608	TC	C	Brain imaging (PET)	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78608	.....	C	Brain imaging (PET)	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78609	26	A	Brain imaging (PET)	1.50	0.51	0.51	0.06	2.07	2.07	XXX
78609	TC	C	Brain imaging (PET)	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78609	.....	C	Brain imaging (PET)	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78610	26	A	Brain flow imaging only	0.30	0.11	0.11	0.01	0.42	0.42	XXX
78610	TC	A	Brain flow imaging only	0.00	1.58	NA	0.10	1.68	NA	XXX
78610	.....	A	Brain flow imaging only	0.30	1.69	NA	0.11	2.10	NA	XXX
78615	26	A	Cerebral vascular flow image	0.42	0.15	0.15	0.02	0.59	0.59	XXX
78615	TC	A	Cerebral vascular flow image	0.00	3.86	NA	0.21	4.07	NA	XXX
78615	.....	A	Cerebral vascular flow image	0.42	4.01	NA	0.23	4.66	NA	XXX
78630	26	A	Cerebrospinal fluid scan	0.68	0.23	0.23	0.03	0.94	0.94	XXX
78630	TC	A	Cerebrospinal fluid scan	0.00	5.05	NA	0.27	5.32	NA	XXX
78630	.....	A	Cerebrospinal fluid scan	0.68	5.28	NA	0.30	6.26	NA	XXX
78635	26	A	CSF ventriculography	0.61	0.23	0.23	0.02	0.86	0.86	XXX
78635	TC	A	CSF ventriculography	0.00	2.55	NA	0.14	2.69	NA	XXX
78635	.....	A	CSF ventriculography	0.61	2.78	NA	0.16	3.55	NA	XXX
78645	26	A	CSF shunt evaluation	0.57	0.19	0.19	0.02	0.78	0.78	XXX
78645	TC	A	CSF shunt evaluation	0.00	3.44	NA	0.18	3.62	NA	XXX
78645	.....	A	CSF shunt evaluation	0.57	3.63	NA	0.20	4.40	NA	XXX
78647	26	A	Cerebrospinal fluid scan	0.90	0.31	0.31	0.04	1.25	1.25	XXX
78647	TC	A	Cerebrospinal fluid scan	0.00	5.93	NA	0.31	6.24	NA	XXX
78647	.....	A	Cerebrospinal fluid scan	0.90	6.24	NA	0.35	7.49	NA	XXX
78650	26	A	CSF leakage imaging	0.61	0.21	0.21	0.03	0.85	0.85	XXX
78650	TC	A	CSF leakage imaging	0.00	4.65	NA	0.24	4.89	NA	XXX
78650	.....	A	CSF leakage imaging	0.61	4.86	NA	0.27	5.74	NA	XXX
78660	26	A	Nuclear exam of tear flow	0.53	0.18	0.18	0.02	0.73	0.73	XXX
78660	TC	A	Nuclear exam of tear flow	0.00	2.13	NA	0.12	2.25	NA	XXX
78660	.....	A	Nuclear exam of tear flow	0.53	2.31	NA	0.14	2.98	NA	XXX
78699	26	C	Nervous system nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78699	TC	C	Nervous system nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78699	.....	C	Nervous system nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78700	26	A	Kidney imaging, static	0.45	0.15	0.15	0.02	0.62	0.62	XXX
78700	TC	A	Kidney imaging, static	0.00	3.06	NA	0.16	3.22	NA	XXX
78700	.....	A	Kidney imaging, static	0.45	3.21	NA	0.18	3.84	NA	XXX
78701	26	A	Kidney imaging with flow	0.49	0.16	0.16	0.02	0.67	0.67	XXX
78701	TC	A	Kidney imaging with flow	0.00	3.57	NA	0.18	3.75	NA	XXX
78701	.....	A	Kidney imaging with flow	0.49	3.73	NA	0.20	4.42	NA	XXX
78704	26	A	Imaging renogram	0.74	0.25	0.25	0.03	1.02	1.02	XXX
78704	TC	A	Imaging renogram	0.00	3.96	NA	0.21	4.17	NA	XXX
78704	.....	A	Imaging renogram	0.74	4.21	NA	0.24	5.19	NA	XXX
78707	26	A	Kidney flow/function image	0.96	0.32	0.32	0.04	1.32	1.32	XXX
78707	TC	A	Kidney flow/function image	0.00	4.48	NA	0.23	4.71	NA	XXX
78707	.....	A	Kidney flow/function image	0.96	4.80	NA	0.27	6.03	NA	XXX
78708	26	A	Kidney flow/function image	1.21	0.41	0.41	0.05	1.67	1.67	XXX
78708	TC	A	Kidney flow/function image	0.00	4.48	NA	0.23	4.71	NA	XXX
78708	.....	A	Kidney flow/function image	1.21	4.89	NA	0.28	6.38	NA	XXX
78709	26	A	Kidney flow/function image	1.41	0.47	0.47	0.06	1.94	1.94	XXX
78709	TC	A	Kidney flow/function image	0.00	4.48	NA	0.23	4.71	NA	XXX
78709	.....	A	Kidney flow/function image	1.41	4.95	NA	0.29	6.65	NA	XXX
78710	26	A	Kidney imaging (3D)	0.66	0.22	0.22	0.03	0.91	0.91	XXX
78710	TC	A	Kidney imaging (3D)	0.00	5.93	NA	0.31	6.24	NA	XXX
78710	.....	A	Kidney imaging (3D)	0.66	6.15	NA	0.34	7.15	NA	XXX
78715	26	A	Renal vascular flow exam	0.30	0.11	0.11	0.01	0.42	0.42	XXX
78715	TC	A	Renal vascular flow exam	0.00	1.58	NA	0.10	1.68	NA	XXX
78715	.....	A	Renal vascular flow exam	0.30	1.69	NA	0.11	2.10	NA	XXX
78725	26	A	Kidney function study	0.38	0.13	0.13	0.02	0.53	0.53	XXX
78725	TC	A	Kidney function study	0.00	1.79	NA	0.11	1.90	NA	XXX
78725	.....	A	Kidney function study	0.38	1.92	NA	0.13	2.43	NA	XXX
78730	26	A	Urinary bladder retention	0.36	0.12	0.12	0.02	0.50	0.50	XXX
78730	TC	A	Urinary bladder retention	0.00	1.46	NA	0.08	1.54	NA	XXX
78730	.....	A	Urinary bladder retention	0.36	1.58	NA	0.10	2.04	NA	XXX
78740	26	A	Ureteral reflux study	0.57	0.19	0.19	0.03	0.79	0.79	XXX
78740	TC	A	Ureteral reflux study	0.00	2.13	NA	0.12	2.25	NA	XXX
78740	.....	A	Ureteral reflux study	0.57	2.32	NA	0.15	3.04	NA	XXX
78760	26	A	Testicular imaging	0.66	0.22	0.22	0.03	0.91	0.91	XXX
78760	TC	A	Testicular imaging	0.00	2.69	NA	0.14	2.83	NA	XXX
78760	.....	A	Testicular imaging	0.66	2.91	NA	0.17	3.74	NA	XXX
78761	26	A	Testicular imaging/flow	0.71	0.24	0.24	0.03	0.98	0.98	XXX
78761	TC	A	Testicular imaging/flow	0.00	3.21	NA	0.17	3.38	NA	XXX
78761	.....	A	Testicular imaging/flow	0.71	3.45	NA	0.20	4.36	NA	XXX
78799	26	C	Genitourinary nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78799	TC	C	Genitourinary nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
78799	.....	C	Genitourinary nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78800	26	A	Tumor imaging, limited area	0.66	0.22	0.22	0.04	0.92	0.92	XXX
78800	TC	A	Tumor imaging, limited area	0.00	3.41	NA	0.18	3.59	NA	XXX
78800	.....	A	Tumor imaging, limited area	0.66	3.63	NA	0.22	4.51	NA	XXX
78801	26	A	Tumor imaging, mult areas	0.79	0.27	0.27	0.05	1.11	1.11	XXX
78801	TC	A	Tumor imaging, mult areas	0.00	4.23	NA	0.22	4.45	NA	XXX
78801	.....	A	Tumor imaging, mult areas	0.79	4.50	NA	0.27	5.56	NA	XXX
78802	26	A	Tumor imaging, whole body	0.86	0.29	0.29	0.04	1.19	1.19	XXX
78802	TC	A	Tumor imaging, whole body	0.00	5.55	NA	0.30	5.85	NA	XXX
78802	.....	A	Tumor imaging, whole body	0.86	5.84	NA	0.34	7.04	NA	XXX
78803	26	A	Tumor imaging (3D)	1.09	0.38	0.38	0.05	1.52	1.52	XXX
78803	TC	A	Tumor imaging (3D)	0.00	6.57	NA	0.35	6.92	NA	XXX
78803	.....	A	Tumor imaging (3D)	1.09	6.95	NA	0.40	8.44	NA	XXX
78804	26	A	Tumor imaging, whole body	1.07	0.37	0.37	0.04	1.48	1.48	XXX
78804	TC	A	Tumor imaging, whole body	0.00	11.09	NA	0.30	11.39	NA	XXX
78804	.....	A	Tumor imaging, whole body	1.07	11.46	NA	0.34	12.87	NA	XXX
78805	26	A	Abscess imaging, ltd area	0.73	0.25	0.25	0.03	1.01	1.01	XXX
78805	TC	A	Abscess imaging, ltd area	0.00	3.41	NA	0.18	3.59	NA	XXX
78805	.....	A	Abscess imaging, ltd area	0.73	3.66	NA	0.21	4.60	NA	XXX
78806	26	A	Abscess imaging, whole body	0.86	0.29	0.29	0.04	1.19	1.19	XXX
78806	TC	A	Abscess imaging, whole body	0.00	6.45	NA	0.35	6.80	NA	XXX
78806	.....	A	Abscess imaging, whole body	0.86	6.74	NA	0.39	7.99	NA	XXX
78807	26	A	Nuclear localization/abscess	1.09	0.39	0.39	0.04	1.52	1.52	XXX
78807	TC	A	Nuclear localization/abscess	0.00	6.57	NA	0.35	6.92	NA	XXX
78807	.....	A	Nuclear localization/abscess	1.09	6.96	NA	0.39	8.44	NA	XXX
78811	26	A	Tumor imaging (pet), limited	1.54	0.53	0.53	0.11	2.18	2.18	XXX
78811	TC	C	Tumor imaging (pet), limited	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78811	.....	C	Tumor imaging (pet), limited	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78812	26	A	Tumor image (pet)/skul-thigh	1.93	0.66	0.66	0.11	2.70	2.70	XXX
78812	TC	C	Tumor image (pet)/skul-thigh	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78812	.....	C	Tumor image (pet)/skul-thigh	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78813	26	A	Tumor image (pet) full body	2.00	0.69	0.69	0.11	2.80	2.80	XXX
78813	TC	C	Tumor image (pet) full body	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78813	.....	C	Tumor image (pet) full body	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78814	26	A	Tumor image pet/ct, limited	2.20	0.76	0.76	0.11	3.07	3.07	XXX
78814	TC	C	Tumor image pet/ct, limited	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78814	.....	C	Tumor image pet/ct, limited	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78815	26	A	Tumorimage pet/ct skul-thigh	2.44	0.84	0.84	0.11	3.39	3.39	XXX
78815	TC	C	Tumorimage pet/ct skul-thigh	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78815	.....	C	Tumorimage pet/ct skul-thigh	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78816	26	A	Tumor image pet/ct full body	2.50	0.86	0.86	0.11	3.47	3.47	XXX
78816	TC	C	Tumor image pet/ct full body	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78816	.....	C	Tumor image pet/ct full body	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78890	26	B	Nuclear medicine data proc	+0.05	0.02	0.02	0.01	0.08	0.08	XXX
78890	TC	B	Nuclear medicine data proc	+0.00	1.31	NA	0.06	1.37	NA	XXX
78890	.....	B	Nuclear medicine data proc	+0.05	1.33	NA	0.07	1.45	NA	XXX
78891	26	B	Nuclear med data proc	+0.10	0.04	0.04	0.01	0.15	0.15	XXX
78891	TC	B	Nuclear med data proc	+0.00	2.63	NA	0.13	2.76	NA	XXX
78891	.....	B	Nuclear med data proc	+0.10	2.67	NA	0.14	2.91	NA	XXX
78999	26	C	Nuclear diagnostic exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78999	TC	C	Nuclear diagnostic exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78999	.....	C	Nuclear diagnostic exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
79005	26	A	Nuclear rx, oral admin	1.80	0.60	0.60	0.08	2.48	2.48	XXX
79005	TC	A	Nuclear rx, oral admin	0.00	2.63	NA	0.14	2.77	NA	XXX
79005	.....	A	Nuclear rx, oral admin	1.80	3.23	NA	0.22	5.25	NA	XXX
79101	26	A	Nuclear rx, iv admin	1.96	0.67	0.67	0.08	2.71	2.71	XXX
79101	TC	A	Nuclear rx, iv admin	0.00	2.63	NA	0.14	2.77	NA	XXX
79101	.....	A	Nuclear rx, iv admin	1.96	3.30	NA	0.22	5.48	NA	XXX
79200	26	A	Nuclear rx, intracav admin	1.99	0.69	0.69	0.09	2.77	2.77	XXX
79200	TC	A	Nuclear rx, intracav admin	0.00	2.63	NA	0.14	2.77	NA	XXX
79200	.....	A	Nuclear rx, intracav admin	1.99	3.32	NA	0.23	5.54	NA	XXX
79300	26	A	Nuclr rx, interstit colloid	1.60	0.56	0.56	0.13	2.29	2.29	XXX
79300	TC	C	Nuclr rx, interstit colloid	0.00	0.00	0.00	0.00	0.00	0.00	XXX
79300	.....	C	Nuclr rx, interstit colloid	0.00	0.00	0.00	0.00	0.00	0.00	XXX
79403	26	A	Hematopoietic nuclear tx	2.25	0.89	0.89	0.10	3.24	3.24	XXX
79403	TC	A	Hematopoietic nuclear tx	0.00	4.28	NA	0.14	4.42	NA	XXX
79403	.....	A	Hematopoietic nuclear tx	2.25	5.17	NA	0.24	7.66	NA	XXX
79440	26	A	Nuclear rx, intra-articular	1.99	0.72	0.72	0.08	2.79	2.79	XXX
79440	TC	A	Nuclear rx, intra-articular	0.00	2.63	NA	0.14	2.77	NA	XXX
79440	.....	A	Nuclear rx, intra-articular	1.99	3.35	NA	0.22	5.56	NA	XXX
79445	26	A	Nuclear rx, intra-arterial	2.40	0.82	0.82	0.12	3.34	3.34	XXX
79445	TC	C	Nuclear rx, intra-arterial	0.00	0.00	0.00	0.00	0.00	0.00	XXX
79445	.....	C	Nuclear rx, intra-arterial	0.00	0.00	0.00	0.00	0.00	0.00	XXX
79999	26	C	Nuclear medicine therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
79999	TC	C	Nuclear medicine therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
79999	.....	C	Nuclear medicine therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
80500	.....	A	Lab pathology consultation	0.37	0.21	0.16	0.01	0.59	0.54	XXX
80502	.....	A	Lab pathology consultation	1.33	0.54	0.54	0.04	1.91	1.91	XXX
83020	26	A	Hemoglobin electrophoresis	0.37	0.15	0.15	0.01	0.53	0.53	XXX
83912	26	A	Genetic examination	0.37	0.12	0.12	0.01	0.50	0.50	XXX
84165	26	A	Protein e-phoresis, serum	0.37	0.14	0.14	0.01	0.52	0.52	XXX
84166	26	A	Protein e-phoresis/urine/csf	0.37	0.14	0.14	0.01	0.52	0.52	XXX
84181	26	A	Western blot test	0.37	0.14	0.14	0.01	0.52	0.52	XXX
84182	26	A	Protein, western blot test	0.37	0.16	0.16	0.02	0.55	0.55	XXX
85060	.....	A	Blood smear interpretation	0.45	0.18	0.18	0.02	0.65	0.65	XXX
85097	.....	A	Bone marrow interpretation	0.94	1.92	0.41	0.04	2.90	1.39	XXX
85390	26	A	Fibrinolysins screen	0.37	0.13	0.13	0.01	0.51	0.51	XXX
85396	.....	A	Clotting assay, whole blood	0.37	NA	0.16	0.04	NA	0.57	XXX
85576	26	A	Blood platelet aggregation	0.37	0.16	0.16	0.01	0.54	0.54	XXX
86077	.....	A	Physician blood bank service	0.94	0.39	0.39	0.03	1.36	1.36	XXX
86078	.....	A	Physician blood bank service	0.94	0.46	0.40	0.03	1.43	1.37	XXX
86079	.....	A	Physician blood bank service	0.94	0.45	0.41	0.03	1.42	1.38	XXX
86255	26	A	Fluorescent antibody, screen	0.37	0.15	0.15	0.01	0.53	0.53	XXX
86256	26	A	Fluorescent antibody, titer	0.37	0.15	0.15	0.01	0.53	0.53	XXX
86320	26	A	Serum immunoelectrophoresis	0.37	0.15	0.15	0.01	0.53	0.53	XXX
86325	26	A	Other immunoelectrophoresis	0.37	0.13	0.13	0.01	0.51	0.51	XXX
86327	26	A	Immunoelectrophoresis assay	0.42	0.18	0.18	0.02	0.62	0.62	XXX
86334	26	A	Immunofix e-phoresis, serum	0.37	0.15	0.15	0.01	0.53	0.53	XXX
86335	26	A	Immunfix e-phorsis/urine/csf	0.37	0.14	0.14	0.01	0.52	0.52	XXX
86485	.....	C	Skin test, candida	0.00	0.00	0.00	0.00	0.00	0.00	XXX
86490	.....	A	Coccidioidomycosis skin test	0.00	0.29	NA	0.02	0.31	NA	XXX
86510	.....	A	Histoplasmosis skin test	0.00	0.32	NA	0.02	0.34	NA	XXX
86580	.....	A	TB intradermal test	0.00	0.25	NA	0.02	0.27	NA	XXX
87164	26	A	Dark field examination	0.37	0.12	0.12	0.01	0.50	0.50	XXX
87207	26	A	Smear, special stain	0.37	0.16	0.16	0.01	0.54	0.54	XXX
88104	26	A	Cytopathology, fluids	0.56	0.24	0.24	0.02	0.82	0.82	XXX
88104	TC	A	Cytopathology, fluids	0.00	0.61	NA	0.02	0.63	NA	XXX
88104	.....	A	Cytopathology, fluids	0.56	0.85	NA	0.04	1.45	NA	XXX
88106	26	A	Cytopathology, fluids	0.56	0.24	0.24	0.02	0.82	0.82	XXX
88106	TC	A	Cytopathology, fluids	0.00	1.11	NA	0.02	1.13	NA	XXX
88106	.....	A	Cytopathology, fluids	0.56	1.35	NA	0.04	1.95	NA	XXX
88107	26	A	Cytopathology, fluids	0.76	0.33	0.33	0.03	1.12	1.12	XXX
88107	TC	A	Cytopathology, fluids	0.00	1.21	NA	0.02	1.23	NA	XXX
88107	.....	A	Cytopathology, fluids	0.76	1.54	NA	0.05	2.35	NA	XXX
88108	26	A	Cytopath, concentrate tech	0.56	0.24	0.24	0.02	0.82	0.82	XXX
88108	TC	A	Cytopath, concentrate tech	0.00	0.97	NA	0.02	0.99	NA	XXX
88108	.....	A	Cytopath, concentrate tech	0.56	1.21	NA	0.04	1.81	NA	XXX
88112	26	A	Cytopath, cell enhance tech	1.18	0.51	0.51	0.02	1.71	1.71	XXX
88112	TC	A	Cytopath, cell enhance tech	0.00	1.46	NA	0.02	1.48	NA	XXX
88112	.....	A	Cytopath, cell enhance tech	1.18	1.97	NA	0.04	3.19	NA	XXX
88125	26	A	Forensic cytopathology	0.26	0.11	0.11	0.01	0.38	0.38	XXX
88125	TC	A	Forensic cytopathology	0.00	0.16	NA	0.01	0.17	NA	XXX
88125	.....	A	Forensic cytopathology	0.26	0.27	NA	0.02	0.55	NA	XXX
88141	.....	A	Cytopath, c/v, interpret	0.42	0.15	0.15	0.02	0.59	0.59	XXX
88160	26	A	Cytopath smear, other source	0.50	0.21	0.21	0.02	0.73	0.73	XXX
88160	TC	A	Cytopath smear, other source	0.00	0.62	NA	0.02	0.64	NA	XXX
88160	.....	A	Cytopath smear, other source	0.50	0.83	NA	0.04	1.37	NA	XXX
88161	26	A	Cytopath smear, other source	0.50	0.21	0.21	0.02	0.73	0.73	XXX
88161	TC	A	Cytopath smear, other source	0.00	0.73	NA	0.02	0.75	NA	XXX
88161	.....	A	Cytopath smear, other source	0.50	0.94	NA	0.04	1.48	NA	XXX
88162	26	A	Cytopath smear, other source	0.76	0.33	0.33	0.03	1.12	1.12	XXX
88162	TC	A	Cytopath smear, other source	0.00	0.69	NA	0.02	0.71	NA	XXX
88162	.....	A	Cytopath smear, other source	0.76	1.02	NA	0.05	1.83	NA	XXX
88172	26	A	Cytopathology eval of fna	0.60	0.26	0.26	0.02	0.88	0.88	XXX
88172	TC	A	Cytopathology eval of fna	0.00	0.47	NA	0.02	0.49	NA	XXX
88172	.....	A	Cytopathology eval of fna	0.60	0.73	NA	0.04	1.37	NA	XXX
88173	26	A	Cytopath eval, fna, report	1.39	0.59	0.59	0.05	2.03	2.03	XXX
88173	TC	A	Cytopath eval, fna, report	0.00	1.55	NA	0.02	1.57	NA	XXX
88173	.....	A	Cytopath eval, fna, report	1.39	2.14	NA	0.07	3.60	NA	XXX
88182	26	A	Cell marker study	0.77	0.33	0.33	0.03	1.13	1.13	XXX
88182	TC	A	Cell marker study	0.00	1.65	NA	0.04	1.69	NA	XXX
88182	.....	A	Cell marker study	0.77	1.98	NA	0.07	2.82	NA	XXX
88184	.....	A	Flowcytometry/ tc, 1 marker	0.00	1.32	NA	0.02	1.34	NA	XXX
88185	.....	A	Flowcytometry/tc, add-on	0.00	0.64	NA	0.02	0.66	NA	ZZZ
88187	.....	A	Flowcytometry/read, 2-8	1.36	0.45	0.45	0.01	1.82	1.82	XXX
88188	.....	A	Flowcytometry/read, 9-15	1.69	0.57	0.57	0.01	2.27	2.27	XXX
88189	.....	A	Flowcytometry/read, 16 & >	2.23	0.75	0.75	0.01	2.99	2.99	XXX
88199	26	C	Cytopathology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88199	TC	C	Cytopathology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88199	.....	C	Cytopathology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
88291	.....	A	Cyto/molecular report	0.52	0.17	0.17	0.02	0.71	0.71	XXX
88299	.....	C	Cytogenetic study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88300	26	A	Surgical path, gross	0.08	0.03	0.03	0.01	0.12	0.12	XXX
88300	TC	A	Surgical path, gross	0.00	0.42	NA	0.01	0.43	NA	XXX
88300	.....	A	Surgical path, gross	0.08	0.45	NA	0.02	0.55	NA	XXX
88302	26	A	Tissue exam by pathologist	0.13	0.06	0.06	0.01	0.20	0.20	XXX
88302	TC	A	Tissue exam by pathologist	0.00	0.97	NA	0.02	0.99	NA	XXX
88302	.....	A	Tissue exam by pathologist	0.13	1.03	NA	0.03	1.19	NA	XXX
88304	26	A	Tissue exam by pathologist	0.22	0.09	0.09	0.01	0.32	0.32	XXX
88304	TC	A	Tissue exam by pathologist	0.00	1.23	NA	0.02	1.25	NA	XXX
88304	.....	A	Tissue exam by pathologist	0.22	1.32	NA	0.03	1.57	NA	XXX
88305	26	A	Tissue exam by pathologist	0.75	0.33	0.33	0.03	1.11	1.11	XXX
88305	TC	A	Tissue exam by pathologist	0.00	1.58	NA	0.04	1.62	NA	XXX
88305	.....	A	Tissue exam by pathologist	0.75	1.91	NA	0.07	2.73	NA	XXX
88307	26	A	Tissue exam by pathologist	1.59	0.68	0.68	0.06	2.33	2.33	XXX
88307	TC	A	Tissue exam by pathologist	0.00	2.48	NA	0.06	2.54	NA	XXX
88307	.....	A	Tissue exam by pathologist	1.59	3.16	NA	0.12	4.87	NA	XXX
88309	26	A	Tissue exam by pathologist	2.28	0.97	0.97	0.08	3.33	3.33	XXX
88309	TC	A	Tissue exam by pathologist	0.00	3.43	NA	0.06	3.49	NA	XXX
88309	.....	A	Tissue exam by pathologist	2.28	4.40	NA	0.14	6.82	NA	XXX
88311	26	A	Decalcify tissue	0.24	0.10	0.10	0.01	0.35	0.35	XXX
88311	TC	A	Decalcify tissue	0.00	0.13	NA	0.01	0.14	NA	XXX
88311	.....	A	Decalcify tissue	0.24	0.23	NA	0.02	0.49	NA	XXX
88312	26	A	Special stains	0.54	0.23	0.23	0.02	0.79	0.79	XXX
88312	TC	A	Special stains	0.00	1.29	NA	0.01	1.30	NA	XXX
88312	.....	A	Special stains	0.54	1.52	NA	0.03	2.09	NA	XXX
88313	26	A	Special stains	0.24	0.10	0.10	0.01	0.35	0.35	XXX
88313	TC	A	Special stains	0.00	1.15	NA	0.01	1.16	NA	XXX
88313	.....	A	Special stains	0.24	1.25	NA	0.02	1.51	NA	XXX
88314	26	A	Histochemical stain	0.45	0.19	0.19	0.02	0.66	0.66	XXX
88314	TC	A	Histochemical stain	0.00	1.88	NA	0.02	1.90	NA	XXX
88314	.....	A	Histochemical stain	0.45	2.07	NA	0.04	2.56	NA	XXX
88318	26	A	Chemical histochemistry	0.42	0.18	0.18	0.02	0.62	0.62	XXX
88318	TC	A	Chemical histochemistry	0.00	1.47	NA	0.01	1.48	NA	XXX
88318	.....	A	Chemical histochemistry	0.42	1.65	NA	0.03	2.10	NA	XXX
88319	26	A	Enzyme histochemistry	0.53	0.22	0.22	0.02	0.77	0.77	XXX
88319	TC	A	Enzyme histochemistry	0.00	3.20	NA	0.02	3.22	NA	XXX
88319	.....	A	Enzyme histochemistry	0.53	3.42	NA	0.04	3.99	NA	XXX
88321	.....	A	Microslide consultation	1.30	0.79	0.56	0.05	2.14	1.91	XXX
88323	26	A	Microslide consultation	1.35	0.57	0.57	0.05	1.97	1.97	XXX
88323	TC	A	Microslide consultation	0.00	1.21	NA	0.02	1.23	NA	XXX
88323	.....	A	Microslide consultation	1.35	1.78	NA	0.07	3.20	NA	XXX
88325	.....	A	Comprehensive review of data	2.22	2.94	0.95	0.07	5.23	3.24	XXX
88329	.....	A	Path consult introp	0.67	0.65	0.29	0.02	1.34	0.98	XXX
88331	26	A	Path consult intraop, 1 bloc	1.19	0.51	0.51	0.04	1.74	1.74	XXX
88331	TC	A	Path consult intraop, 1 bloc	0.00	0.59	NA	0.04	0.63	NA	XXX
88331	.....	A	Path consult intraop, 1 bloc	1.19	1.10	NA	0.08	2.37	NA	XXX
88332	26	A	Path consult intraop, add'l	0.59	0.25	0.25	0.02	0.86	0.86	XXX
88332	TC	A	Path consult intraop, add'l	0.00	0.21	NA	0.02	0.23	NA	XXX
88332	.....	A	Path consult intraop, add'l	0.59	0.46	NA	0.04	1.09	NA	XXX
88333	26	A	Intraop cyto path consult, 1	1.20	0.53	0.53	0.04	1.77	1.77	XXX
88333	TC	A	Intraop cyto path consult, 1	0.00	0.55	NA	0.04	0.59	NA	XXX
88333	.....	A	Intraop cyto path consult, 1	1.20	1.08	NA	0.08	2.36	NA	XXX
88334	26	A	Intraop cyto path consult, 2	0.59	0.26	0.26	0.02	0.87	0.87	XXX
88334	TC	A	Intraop cyto path consult, 2	0.00	0.34	NA	0.02	0.36	NA	XXX
88334	.....	A	Intraop cyto path consult, 2	0.59	0.60	NA	0.04	1.23	NA	XXX
88342	26	A	Immunohistochemistry	0.85	0.36	0.36	0.03	1.24	1.24	XXX
88342	TC	A	Immunohistochemistry	0.00	1.10	NA	0.02	1.12	NA	XXX
88342	.....	A	Immunohistochemistry	0.85	1.46	NA	0.05	2.36	NA	XXX
88346	26	A	Immunofluorescent study	0.86	0.36	0.36	0.03	1.25	1.25	XXX
88346	TC	A	Immunofluorescent study	0.00	1.21	NA	0.02	1.23	NA	XXX
88346	.....	A	Immunofluorescent study	0.86	1.57	NA	0.05	2.48	NA	XXX
88347	26	A	Immunofluorescent study	0.86	0.35	0.35	0.03	1.24	1.24	XXX
88347	TC	A	Immunofluorescent study	0.00	0.91	NA	0.02	0.93	NA	XXX
88347	.....	A	Immunofluorescent study	0.86	1.26	NA	0.05	2.17	NA	XXX
88348	26	A	Electron microscopy	1.51	0.64	0.64	0.06	2.21	2.21	XXX
88348	TC	A	Electron microscopy	0.00	8.74	NA	0.07	8.81	NA	XXX
88348	.....	A	Electron microscopy	1.51	9.38	NA	0.13	11.02	NA	XXX
88349	26	A	Scanning electron microscopy	0.76	0.33	0.33	0.03	1.12	1.12	XXX
88349	TC	A	Scanning electron microscopy	0.00	3.24	NA	0.06	3.30	NA	XXX
88349	.....	A	Scanning electron microscopy	0.76	3.57	NA	0.09	4.42	NA	XXX
88355	26	A	Analysis, skeletal muscle	1.85	0.79	0.79	0.07	2.71	2.71	XXX
88355	TC	A	Analysis, skeletal muscle	0.00	8.00	NA	0.06	8.06	NA	XXX
88355	.....	A	Analysis, skeletal muscle	1.85	8.79	NA	0.13	10.77	NA	XXX
88356	26	A	Analysis, nerve	3.02	1.26	1.26	0.12	4.40	4.40	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
88356	TC	A	Analysis, nerve	0.00	2.93	NA	0.07	3.00	NA	XXX
88356	.....	A	Analysis, nerve	3.02	4.19	NA	0.19	7.40	NA	XXX
88358	26	A	Analysis, tumor	0.95	0.40	0.40	0.10	1.45	1.45	XXX
88358	TC	A	Analysis, tumor	0.00	0.44	NA	0.07	0.51	NA	XXX
88358	.....	A	Analysis, tumor	0.95	0.84	NA	0.17	1.96	NA	XXX
88360	26	A	Tumor immunohistochem/manual	1.10	0.47	0.47	0.06	1.63	1.63	XXX
88360	TC	A	Tumor immunohistochem/manual	0.00	1.26	NA	0.02	1.28	NA	XXX
88360	.....	A	Tumor immunohistochem/manual	1.10	1.73	NA	0.08	2.91	NA	XXX
88361	26	A	Tumor immunohistochem/comput	1.18	0.49	0.49	0.10	1.77	1.77	XXX
88361	TC	A	Tumor immunohistochem/comput	0.00	2.54	NA	0.07	2.61	NA	XXX
88361	.....	A	Tumor immunohistochem/comput	1.18	3.03	NA	0.17	4.38	NA	XXX
88362	26	A	Nerve teasing preparations	2.17	0.92	0.92	0.09	3.18	3.18	XXX
88362	TC	A	Nerve teasing preparations	0.00	3.78	NA	0.06	3.84	NA	XXX
88362	.....	A	Nerve teasing preparations	2.17	4.70	NA	0.15	7.02	NA	XXX
88365	26	A	Insitu hybridization (fish)	1.20	0.51	0.51	0.03	1.74	1.74	XXX
88365	TC	A	Insitu hybridization (fish)	0.00	1.62	NA	0.02	1.64	NA	XXX
88365	.....	A	Insitu hybridization (fish)	1.20	2.13	NA	0.05	3.38	NA	XXX
88367	26	A	Insitu hybridization, auto	1.30	0.54	0.54	0.06	1.90	1.90	XXX
88367	TC	A	Insitu hybridization, auto	0.00	3.50	NA	0.06	3.56	NA	XXX
88367	.....	A	Insitu hybridization, auto	1.30	4.04	NA	0.12	5.46	NA	XXX
88368	26	A	Insitu hybridization, manual	1.40	0.60	0.60	0.06	2.06	2.06	XXX
88368	TC	A	Insitu hybridization, manual	0.00	1.80	NA	0.06	1.86	NA	XXX
88368	.....	A	Insitu hybridization, manual	1.40	2.40	NA	0.12	3.92	NA	XXX
88371	26	A	Protein, western blot tissue	0.37	0.13	0.13	0.01	0.51	0.51	XXX
88372	26	A	Protein analysis w/probe	0.37	0.16	0.16	0.01	0.54	0.54	XXX
88380	26	C	Microdissection	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88380	TC	C	Microdissection	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88380	.....	C	Microdissection	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88384	26	C	Eval molecular probes, 11-50	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88384	TC	C	Eval molecular probes, 11-50	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88384	.....	C	Eval molecular probes, 11-50	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88385	26	A	Eval molecul probes, 51-250	1.50	0.65	0.65	0.06	2.21	2.21	XXX
88385	TC	C	Eval molecul probes, 51-250	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88385	.....	C	Eval molecul probes, 51-250	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88386	26	A	Eval molecul probes, 251-500	1.88	0.82	0.82	0.08	2.78	2.78	XXX
88386	TC	C	Eval molecul probes, 251-500	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88386	.....	C	Eval molecul probes, 251-500	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88399	26	C	Surgical pathology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88399	TC	C	Surgical pathology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88399	.....	C	Surgical pathology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
89049	.....	A	Chct for mal hyperthermia	1.40	3.56	0.27	0.06	5.02	1.73	XXX
89060	26	A	Exam,synovial fluid crystals	0.37	0.16	0.16	0.01	0.54	0.54	XXX
89100	.....	A	Sample intestinal contents	0.60	1.84	0.21	0.03	2.47	0.84	XXX
89105	.....	A	Sample intestinal contents	0.50	2.23	0.17	0.02	2.75	0.69	XXX
89130	.....	A	Sample stomach contents	0.45	1.75	0.13	0.02	2.22	0.60	XXX
89132	.....	A	Sample stomach contents	0.19	1.55	0.06	0.01	1.75	0.26	XXX
89135	.....	A	Sample stomach contents	0.79	1.90	0.25	0.04	2.73	1.08	XXX
89136	.....	A	Sample stomach contents	0.21	1.74	0.09	0.01	1.96	0.31	XXX
89140	.....	A	Sample stomach contents	0.94	2.09	0.27	0.04	3.07	1.25	XXX
89141	.....	A	Sample stomach contents	0.85	2.80	0.33	0.03	3.68	1.21	XXX
89220	.....	A	Sputum specimen collection	0.00	0.43	NA	0.02	0.45	NA	XXX
89230	.....	A	Collect sweat for test	0.00	0.11	NA	0.02	0.13	NA	XXX
89240	.....	C	Pathology lab procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90281	.....	I	Human ig, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90283	.....	I	Human ig, iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90287	.....	I	Botulinum antitoxin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90288	.....	I	Botulism ig, iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90291	.....	I	Cmv ig, iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90296	.....	E	Diphtheria antitoxin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90371	.....	E	Hep b ig, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90375	.....	E	Rabies ig, im/sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90376	.....	E	Rabies ig, heat treated	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90378	.....	X	Rsv ig, im, 50mg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90379	.....	I	Rsv ig, iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90384	.....	I	Rh ig, full-dose, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90385	.....	E	Rh ig, minidose, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90386	.....	I	Rh ig, iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90389	.....	I	Tetanus ig, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90393	.....	E	Vaccina ig, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90396	.....	E	Varicella-zoster ig, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90399	.....	I	Immune globulin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90465	.....	A	Immune admin 1 inj, < 8 yrs	0.17	0.31	NA	0.01	0.49	NA	XXX
90466	.....	A	Immune admin addl inj, < 8 y	0.15	0.13	NA	0.01	0.29	NA	ZZZ
90467	.....	R	Immune admin o or n, < 8 yrs	0.17	0.17	0.09	0.01	0.35	0.27	XXX
90468	.....	R	Immune admin o/n, addl < 8 y	0.15	0.11	0.06	0.01	0.27	0.22	ZZZ

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[3] +Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
90471	.....	A	Immunization admin	0.17	0.31	NA	0.01	0.49	NA	XXX
90472	.....	A	Immunization admin, each add	0.15	0.13	NA	0.01	0.29	NA	ZZZ
90473	.....	R	Immune admin oral/nasal	0.17	0.19	0.07	0.01	0.37	0.25	XXX
90474	.....	R	Immune admin oral/nasal addl	0.15	0.10	0.06	0.01	0.26	0.22	ZZZ
90476	.....	E	Adenovirus vaccine, type 4	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90477	.....	E	Adenovirus vaccine, type 7	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90581	.....	E	Anthrax vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90585	.....	E	Bcg vaccine, percut	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90586	.....	E	Bcg vaccine, intravesical	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90632	.....	E	Hep a vaccine, adult im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90633	.....	E	Hep a vacc, ped/adol, 2 dose	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90634	.....	E	Hep a vacc, ped/adol, 3 dose	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90636	.....	E	Hep a/hep b vacc, adult im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90645	.....	E	Hib vaccine, hboc, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90646	.....	E	Hib vaccine, prp-d, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90647	.....	E	Hib vaccine, prp-omp, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90648	.....	E	Hib vaccine, prp-t, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90649	.....	E	H papilloma vacc 3 dose im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90655	.....	X	Flu vaccine no preserv 6-35m	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90656	.....	X	Flu vaccine no preserv 3 & >	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90657	.....	X	Flu vaccine, 6-35 mo, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90658	.....	X	Flu vaccine age 3 & over, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90660	.....	X	Flu vaccine, nasal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90665	.....	E	Lyme disease vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90669	.....	N	Pneumococcal vacc, ped <5	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90675	.....	E	Rabies vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90676	.....	E	Rabies vaccine, id	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90680	.....	E	Rotovirus vacc 3 dose, oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90690	.....	E	Typhoid vaccine, oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90691	.....	E	Typhoid vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90692	.....	E	Typhoid vaccine, h-p, sc/id	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90693	.....	E	Typhoid vaccine, akd, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90698	.....	E	Dtap-hib-ip vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90700	.....	E	Dtap vaccine, < 7 yrs, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90701	.....	E	Dtp vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90702	.....	E	Dt vaccine < 7, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90703	.....	E	Tetanus vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90704	.....	E	Mumps vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90705	.....	E	Measles vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90706	.....	E	Rubella vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90707	.....	E	Mmr vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90708	.....	E	Measles-rubella vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90710	.....	E	Mmrv vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90712	.....	E	Oral poliovirus vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90713	.....	E	Poliovirus, ipv, sc/im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90714	.....	E	Td vaccine no prsrv >/= 7 im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90715	.....	E	Tdap vaccine >7 im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90716	.....	E	Chicken pox vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90717	.....	E	Yellow fever vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90718	.....	E	Td vaccine > 7, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90719	.....	E	Diphtheria vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90720	.....	E	Dtp/hib vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90721	.....	E	Dtap/hib vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90723	.....	I	Dtap-hep b-ipv vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90725	.....	E	Cholera vaccine, injectable	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90727	.....	E	Plague vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90732	.....	X	Pneumococcal vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90733	.....	E	Meningococcal vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90734	.....	E	Meningococcal vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90735	.....	E	Encephalitis vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90736	.....	E	Zoster vacc, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90740	.....	X	Hepb vacc, ill pat 3 dose im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90743	.....	X	Hep b vacc, adol, 2 dose, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90744	.....	X	Hepb vacc ped/adol 3 dose im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90746	.....	X	Hep b vaccine, adult, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90747	.....	X	Hepb vacc, ill pat 4 dose im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90748	.....	I	Hep b/hib vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90749	.....	E	Vaccine toxoid	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90760	.....	A	Hydration iv infusion, init	0.17	1.43	1.43	0.07	1.67	1.67	XXX
90761	.....	A	Hydrate iv infusion, add-on	0.09	0.40	0.40	0.04	0.53	0.53	ZZZ
90765	.....	A	Ther/proph/diag iv inf, init	0.21	1.76	1.76	0.07	2.04	2.04	XXX
90766	.....	A	Ther/proph/dg iv inf, add-on	0.18	0.46	0.46	0.04	0.68	0.68	ZZZ
90767	.....	A	Tx/proph/dg addl seq iv inf	0.19	0.89	0.89	0.04	1.12	1.12	ZZZ
90768	.....	A	Ther/diag concurrent inf	0.17	0.44	0.44	0.04	0.65	0.65	ZZZ
90772	.....	A	Ther/proph/diag inj, sc/im	0.17	0.31	0.31	0.01	0.49	0.49	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
90773		A	Ther/proph/diag inj, ia	0.17	0.32	0.32	0.02	0.51	0.51	XXX
90774		A	Ther/proph/diag inj, iv push	0.18	1.30	1.30	0.04	1.52	1.52	XXX
90775		A	Ther/proph/diag inj add-on	0.10	0.57	0.57	0.04	0.71	0.71	ZZZ
90779		C	Ther/prop/diag inj/inf proc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90801		A	Psy dx interview	2.80	1.17	0.93	0.06	4.03	3.79	XXX
90802		A	Intac psy dx interview	3.01	1.20	0.98	0.07	4.28	4.06	XXX
90804		A	Psytx, office, 20-30 min	1.21	0.49	0.38	0.03	1.73	1.62	XXX
90805		A	Psytx, off, 20-30 min w/e&m	1.37	0.50	0.42	0.03	1.90	1.82	XXX
90806		A	Psytx, off, 45-50 min	1.86	0.70	0.60	0.04	2.60	2.50	XXX
90807		A	Psytx, off, 45-50 min w/e&m	2.02	0.70	0.63	0.05	2.77	2.70	XXX
90808		A	Psytx, office, 75-80 min	2.79	1.03	0.90	0.06	3.88	3.75	XXX
90809		A	Psytx, off, 75-80, w/e&m	2.95	1.00	0.92	0.07	4.02	3.94	XXX
90810		A	Intac psytx, off, 20-30 min	1.32	0.51	0.42	0.04	1.87	1.78	XXX
90811		A	Intac psytx, 20-30, w/e&m	1.48	0.57	0.46	0.04	2.09	1.98	XXX
90812		A	Intac psytx, off, 45-50 min	1.97	0.79	0.64	0.04	2.80	2.65	XXX
90813		A	Intac psytx, 45-50 min w/e&m	2.13	0.77	0.67	0.05	2.95	2.85	XXX
90814		A	Intac psytx, off, 75-80 min	2.90	1.10	0.98	0.06	4.06	3.94	XXX
90815		A	Intac psytx, 75-80 w/e&m	3.06	1.05	0.95	0.07	4.18	4.08	XXX
90816		A	Psytx, hosp, 20-30 min	1.25	NA	0.46	0.03	NA	1.74	XXX
90817		A	Psytx, hosp, 20-30 min w/e&m	1.41	NA	0.46	0.03	NA	1.90	XXX
90818		A	Psytx, hosp, 45-50 min	1.89	NA	0.69	0.04	NA	2.62	XXX
90819		A	Psytx, hosp, 45-50 min w/e&m	2.05	NA	0.65	0.05	NA	2.75	XXX
90821		A	Psytx, hosp, 75-80 min	2.83	NA	1.01	0.06	NA	3.90	XXX
90822		A	Psytx, hosp, 75-80 min w/e&m	2.99	NA	0.95	0.08	NA	4.02	XXX
90823		A	Intac psytx, hosp, 20-30 min	1.36	NA	0.48	0.03	NA	1.87	XXX
90824		A	Intac psytx, hsp 20-30 w/e&m	1.52	NA	0.49	0.04	NA	2.05	XXX
90826		A	Intac psytx, hosp, 45-50 min	2.01	NA	0.72	0.05	NA	2.78	XXX
90827		A	Intac psytx, hsp 45-50 w/e&m	2.16	NA	0.68	0.05	NA	2.89	XXX
90828		A	Intac psytx, hosp, 75-80 min	2.94	NA	1.06	0.06	NA	4.06	XXX
90829		A	Intac psytx, hsp 75-80 w/e&m	3.10	NA	0.98	0.07	NA	4.15	XXX
90845		A	Psychoanalysis	1.79	0.58	0.55	0.04	2.41	2.38	XXX
90846		R	Family psytx w/o patient	1.83	0.65	0.65	0.04	2.52	2.52	XXX
90847		R	Family psytx w/patient	2.21	0.82	0.76	0.05	3.08	3.02	XXX
90849		R	Multiple family group psytx	0.59	0.27	0.24	0.02	0.88	0.85	XXX
90853		A	Group psychotherapy	0.59	0.25	0.23	0.01	0.85	0.83	XXX
90857		A	Intac group psytx	0.63	0.29	0.25	0.01	0.93	0.89	XXX
90862		A	Medication management	0.95	0.40	0.32	0.02	1.37	1.29	XXX
90865		A	Narcosynthesis	2.84	1.36	0.91	0.12	4.32	3.87	XXX
90870		A	Electroconvulsive therapy	1.88	1.94	0.59	0.04	3.86	2.51	000
90875		N	Psychophysiological therapy	+1.20	0.90	0.46	0.04	2.14	1.70	XXX
90876		N	Psychophysiological therapy	+1.90	1.16	0.73	0.05	3.11	2.68	XXX
90880		A	Hypnotherapy	2.19	1.04	0.69	0.05	3.28	2.93	XXX
90882		N	Environmental manipulation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90885		B	Psy evaluation of records	+0.97	0.37	0.37	0.02	1.36	1.36	XXX
90887		B	Consultation with family	+1.48	0.82	0.56	0.04	2.34	2.08	XXX
90889		B	Preparation of report	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90899		C	Psychiatric service/therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90901		A	Biofeedback train, any meth	0.41	0.65	0.14	0.02	1.08	0.57	000
90911		A	Biofeedback peri/uro/rectal	0.89	1.56	0.31	0.06	2.51	1.26	000
90918		I	ESRD related services, month	+11.16	6.13	6.13	0.36	17.65	17.65	XXX
90919		I	ESRD related services, month	+8.53	4.01	4.01	0.29	12.83	12.83	XXX
90920		I	ESRD related services, month	+7.26	3.76	3.76	0.23	11.25	11.25	XXX
90921		I	ESRD related services, month	+4.46	2.45	2.45	0.14	7.05	7.05	XXX
90922		I	ESRD related services, day	+0.37	0.21	0.21	0.01	0.59	0.59	XXX
90923		I	Esrd related services, day	+0.28	0.13	0.13	0.01	0.42	0.42	XXX
90924		I	Esrd related services, day	+0.24	0.12	0.12	0.01	0.37	0.37	XXX
90925		I	Esrd related services, day	+0.15	0.08	0.08	0.01	0.24	0.24	XXX
90935		A	Hemodialysis, one evaluation	1.22	NA	0.67	0.04	NA	1.93	000
90937		A	Hemodialysis, repeated eval	2.11	NA	0.97	0.07	NA	3.15	000
90940		X	Hemodialysis access study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90945		A	Dialysis, one evaluation	1.28	NA	0.69	0.04	NA	2.01	000
90947		A	Dialysis, repeated eval	2.16	NA	0.99	0.07	NA	3.22	000
90989		X	Dialysis training, complete	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90993		X	Dialysis training, incompl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90997		A	Hemoperfusion	1.84	NA	0.66	0.06	NA	2.56	000
90999		C	Dialysis procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
91000	26	A	Esophageal intubation	0.73	0.25	0.25	0.03	1.01	1.01	000
91000	TC	A	Esophageal intubation	0.00	0.08	NA	0.01	0.09	NA	000
91000		A	Esophageal intubation	0.73	0.33	NA	0.04	1.10	NA	000
91010	26	A	Esophagus motility study	1.25	0.44	0.44	0.06	1.75	1.75	000
91010	TC	A	Esophagus motility study	0.00	3.98	NA	0.06	4.04	NA	000
91010		A	Esophagus motility study	1.25	4.42	NA	0.12	5.79	NA	000
91011	26	A	Esophagus motility study	1.50	0.53	0.53	0.07	2.10	2.10	000
91011	TC	A	Esophagus motility study	0.00	4.71	NA	0.06	4.77	NA	000
91011		A	Esophagus motility study	1.50	5.24	NA	0.13	6.87	NA	000

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
91012	26	A	Esophagus motility study	1.46	0.51	0.51	0.06	2.03	2.03	000
91012	TC	A	Esophagus motility study	0.00	5.26	NA	0.07	5.33	NA	000
91012	.....	A	Esophagus motility study	1.46	5.77	NA	0.13	7.36	NA	000
91020	26	A	Gastric motility studies	1.44	0.49	0.49	0.07	2.00	2.00	000
91020	TC	A	Gastric motility studies	0.00	4.04	NA	0.06	4.10	NA	000
91020	.....	A	Gastric motility studies	1.44	4.53	NA	0.13	6.10	NA	000
91022	26	A	Duodenal motility study	1.44	0.51	0.51	0.07	2.02	2.02	000
91022	TC	A	Duodenal motility study	0.00	3.90	NA	0.06	3.96	NA	000
91022	.....	A	Duodenal motility study	1.44	4.41	NA	0.13	5.98	NA	000
91030	26	A	Acid perfusion of esophagus	0.91	0.32	0.32	0.04	1.27	1.27	000
91030	TC	A	Acid perfusion of esophagus	0.00	2.12	NA	0.02	2.14	NA	000
91030	.....	A	Acid perfusion of esophagus	0.91	2.44	NA	0.06	3.41	NA	000
91034	26	A	Gastroesophageal reflux test	0.97	0.34	0.34	0.06	1.37	1.37	000
91034	TC	A	Gastroesophageal reflux test	0.00	4.91	NA	0.06	4.97	NA	000
91034	.....	A	Gastroesophageal reflux test	0.97	5.25	NA	0.12	6.34	NA	000
91035	26	A	G-esoph reflx tst w/electrod	1.59	0.56	0.56	0.06	2.21	2.21	000
91035	TC	A	G-esoph reflx tst w/electrod	0.00	10.27	NA	0.06	10.33	NA	000
91035	.....	A	G-esoph reflx tst w/electrod	1.59	10.83	NA	0.12	12.54	NA	000
91037	26	A	Esoph imped function test	0.97	0.34	0.34	0.06	1.37	1.37	000
91037	TC	A	Esoph imped function test	0.00	2.60	NA	0.06	2.66	NA	000
91037	.....	A	Esoph imped function test	0.97	2.94	NA	0.12	4.03	NA	000
91038	26	A	Esoph imped funct test > 1h	1.10	0.39	0.39	0.06	1.55	1.55	000
91038	TC	A	Esoph imped funct test > 1h	0.00	1.84	NA	0.06	1.90	NA	000
91038	.....	A	Esoph imped funct test > 1h	1.10	2.23	NA	0.12	3.45	NA	000
91040	26	A	Esoph balloon distension tst	0.97	0.34	0.34	0.06	1.37	1.37	000
91040	TC	A	Esoph balloon distension tst	0.00	10.82	NA	0.06	10.88	NA	000
91040	.....	A	Esoph balloon distension tst	0.97	11.16	NA	0.12	12.25	NA	000
91052	26	A	Gastric analysis test	0.79	0.28	0.28	0.03	1.10	1.10	000
91052	TC	A	Gastric analysis test	0.00	2.18	NA	0.02	2.20	NA	000
91052	.....	A	Gastric analysis test	0.79	2.46	NA	0.05	3.30	NA	000
91055	26	A	Gastric intubation for smear	0.94	0.27	0.27	0.05	1.26	1.26	000
91055	TC	A	Gastric intubation for smear	0.00	2.68	NA	0.02	2.70	NA	000
91055	.....	A	Gastric intubation for smear	0.94	2.95	NA	0.07	3.96	NA	000
91060	26	A	Gastric saline load test	0.45	0.14	0.14	0.03	0.62	0.62	000
91060	TC	A	Gastric saline load test	0.00	1.83	NA	0.02	1.85	NA	000
91060	.....	A	Gastric saline load test	0.45	1.97	NA	0.05	2.47	NA	000
91065	26	A	Breath hydrogen test	0.20	0.07	0.07	0.01	0.28	0.28	000
91065	TC	A	Breath hydrogen test	0.00	1.39	NA	0.02	1.41	NA	000
91065	.....	A	Breath hydrogen test	0.20	1.46	NA	0.03	1.69	NA	000
91100	.....	A	Pass intestine bleeding tube	1.08	2.80	0.28	0.07	3.95	1.43	000
91105	.....	A	Gastric intubation treatment	0.37	2.11	0.09	0.03	2.51	0.49	000
91110	26	A	Gi tract capsule endoscopy	3.64	1.28	1.28	0.09	5.01	5.01	XXX
91110	TC	A	Gi tract capsule endoscopy	0.00	20.96	NA	0.07	21.03	NA	XXX
91110	.....	A	Gi tract capsule endoscopy	3.64	22.24	NA	0.16	26.04	NA	XXX
91120	26	A	Rectal sensation test	0.97	0.34	0.34	0.07	1.38	1.38	XXX
91120	TC	A	Rectal sensation test	0.00	10.67	NA	0.04	10.71	NA	XXX
91120	.....	A	Rectal sensation test	0.97	11.01	NA	0.11	12.09	NA	XXX
91122	26	A	Anal pressure record	1.77	0.60	0.60	0.13	2.50	2.50	000
91122	TC	A	Anal pressure record	0.00	4.51	NA	0.08	4.59	NA	000
91122	.....	A	Anal pressure record	1.77	5.11	NA	0.21	7.09	NA	000
91123	.....	B	Irrigate fecal impaction	0.00	0.00	0.00	0.00	0.00	0.00	XXX
91132	26	A	Electrogastrography	0.52	0.18	0.18	0.02	0.72	0.72	XXX
91132	TC	C	Electrogastrography	0.00	0.00	0.00	0.00	0.00	0.00	XXX
91132	.....	C	Electrogastrography	0.00	0.00	0.00	0.00	0.00	0.00	XXX
91133	26	A	Electrogastrography w/test	0.66	0.23	0.23	0.03	0.92	0.92	XXX
91133	TC	C	Electrogastrography w/test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
91133	.....	C	Electrogastrography w/test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
91299	26	C	Gastroenterology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
91299	TC	C	Gastroenterology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
91299	.....	C	Gastroenterology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92002	.....	A	Eye exam, new patient	0.88	0.97	0.34	0.02	1.87	1.24	XXX
92004	.....	A	Eye exam, new patient	1.67	1.70	0.68	0.04	3.41	2.39	XXX
92012	.....	A	Eye exam established pat	0.67	1.03	0.29	0.02	1.72	0.98	XXX
92014	.....	A	Eye exam & treatment	1.10	1.41	0.47	0.03	2.54	1.60	XXX
92015	.....	N	Refraction	+0.38	1.49	0.15	0.01	1.88	0.54	XXX
92018	.....	A	New eye exam & treatment	2.50	NA	1.07	0.07	NA	3.64	XXX
92019	.....	A	Eye exam & treatment	1.31	NA	0.56	0.03	NA	1.90	XXX
92020	.....	A	Special eye evaluation	0.37	0.34	0.16	0.01	0.72	0.54	XXX
92060	26	A	Special eye evaluation	0.69	0.29	0.29	0.02	1.00	1.00	XXX
92060	TC	A	Special eye evaluation	0.00	0.44	NA	0.01	0.45	NA	XXX
92060	.....	A	Special eye evaluation	0.69	0.73	NA	0.03	1.45	NA	XXX
92065	26	A	Orthoptic/pleoptic training	0.37	0.15	0.15	0.01	0.53	0.53	XXX
92065	TC	A	Orthoptic/pleoptic training	0.00	0.38	NA	0.01	0.39	NA	XXX
92065	.....	A	Orthoptic/pleoptic training	0.37	0.53	NA	0.02	0.92	NA	XXX
92070	.....	A	Fitting of contact lens	0.70	1.07	0.32	0.02	1.79	1.04	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
92081	26	A	Visual field examination(s)	0.36	0.15	0.15	0.01	0.52	0.52	XXX
92081	TC	A	Visual field examination(s)	0.00	0.79	NA	0.01	0.80	NA	XXX
92081		A	Visual field examination(s)	0.36	0.94	NA	0.02	1.32	NA	XXX
92082	26	A	Visual field examination(s)	0.44	0.19	0.19	0.01	0.64	0.64	XXX
92082	TC	A	Visual field examination(s)	0.00	1.04	NA	0.01	1.05	NA	XXX
92082		A	Visual field examination(s)	0.44	1.23	NA	0.02	1.69	NA	XXX
92083	26	A	Visual field examination(s)	0.50	0.22	0.22	0.01	0.73	0.73	XXX
92083	TC	A	Visual field examination(s)	0.00	1.21	NA	0.01	1.22	NA	XXX
92083		A	Visual field examination(s)	0.50	1.43	NA	0.02	1.95	NA	XXX
92100	A		Serial tonometry exam(s)	0.92	1.35	0.36	0.02	2.29	1.30	XXX
92120		A	Tonography & eye evaluation	0.81	1.07	0.32	0.02	1.90	1.15	XXX
92130		A	Water provocation tonography	0.81	1.28	0.37	0.02	2.11	1.20	XXX
92135	26	A	Opthalmic dx imaging	0.35	0.15	0.15	0.01	0.51	0.51	XXX
92135	TC	A	Opthalmic dx imaging	0.00	0.64	NA	0.01	0.65	NA	XXX
92135		A	Opthalmic dx imaging	0.35	0.79	NA	0.02	1.16	NA	XXX
92136	26	A	Ophthalmic biometry	0.54	0.24	0.24	0.01	0.79	0.79	XXX
92136	TC	A	Ophthalmic biometry	0.00	1.41	NA	0.07	1.48	NA	XXX
92136		A	Ophthalmic biometry	0.54	1.65	NA	0.08	2.27	NA	XXX
92140		A	Glaucoma provocative tests	0.50	0.99	0.21	0.01	1.50	0.72	XXX
92225		A	Special eye exam, initial	0.38	0.22	0.16	0.01	0.61	0.55	XXX
92226		A	Special eye exam, subsequent	0.33	0.21	0.14	0.01	0.55	0.48	XXX
92230		A	Eye exam with photos	0.60	1.53	0.20	0.02	2.15	0.82	XXX
92235	26	A	Eye exam with photos	0.81	0.37	0.37	0.02	1.20	1.20	XXX
92235	TC	A	Eye exam with photos	0.00	2.25	NA	0.06	2.31	NA	XXX
92235		A	Eye exam with photos	0.81	2.62	NA	0.08	3.51	NA	XXX
92240	26	A	Icg angiography	1.10	0.50	0.50	0.03	1.63	1.63	XXX
92240	TC	A	Icg angiography	0.00	5.62	NA	0.06	5.68	NA	XXX
92240		A	Icg angiography	1.10	6.12	NA	0.09	7.31	NA	XXX
92250	26	A	Eye exam with photos	0.44	0.19	0.19	0.01	0.64	0.64	XXX
92250	TC	A	Eye exam with photos	0.00	1.34	NA	0.01	1.35	NA	XXX
92250		A	Eye exam with photos	0.44	1.53	NA	0.02	1.99	NA	XXX
92260		A	Ophthalmoscopy/dynamometry	0.20	0.26	0.09	0.01	0.47	0.30	XXX
92265	26	A	Eye muscle evaluation	0.81	0.28	0.28	0.04	1.13	1.13	XXX
92265	TC	A	Eye muscle evaluation	0.00	1.21	NA	0.02	1.23	NA	XXX
92265		A	Eye muscle evaluation	0.81	1.49	NA	0.06	2.36	NA	XXX
92270	26	A	Electro-oculography	0.81	0.33	0.33	0.03	1.17	1.17	XXX
92270	TC	A	Electro-oculography	0.00	1.20	NA	0.02	1.22	NA	XXX
92270		A	Electro-oculography	0.81	1.53	NA	0.05	2.39	NA	XXX
92275	26	A	Electroretinography	1.01	0.43	0.43	0.03	1.47	1.47	XXX
92275	TC	A	Electroretinography	0.00	1.51	NA	0.02	1.53	NA	XXX
92275		A	Electroretinography	1.01	1.94	NA	0.05	3.00	NA	XXX
92283	26	A	Color vision examination	0.17	0.07	0.07	0.01	0.25	0.25	XXX
92283	TC	A	Color vision examination	0.00	0.77	NA	0.01	0.78	NA	XXX
92283		A	Color vision examination	0.17	0.84	NA	0.02	1.03	NA	XXX
92284	26	A	Dark adaptation eye exam	0.24	0.08	0.08	0.01	0.33	0.33	XXX
92284	TC	A	Dark adaptation eye exam	0.00	1.81	NA	0.01	1.82	NA	XXX
92284		A	Dark adaptation eye exam	0.24	1.89	NA	0.02	2.15	NA	XXX
92285	26	A	Eye photography	0.20	0.09	0.09	0.01	0.30	0.30	XXX
92285	TC	A	Eye photography	0.00	0.90	NA	0.01	0.91	NA	XXX
92285		A	Eye photography	0.20	0.99	NA	0.02	1.21	NA	XXX
92286	26	A	Internal eye photography	0.66	0.29	0.29	0.02	0.97	0.97	XXX
92286	TC	A	Internal eye photography	0.00	2.77	NA	0.02	2.79	NA	XXX
92286		A	Internal eye photography	0.66	3.06	NA	0.04	3.76	NA	XXX
92287		A	Internal eye photography	0.81	2.39	0.31	0.02	3.22	1.14	XXX
92310		N	Contact lens fitting	+1.17	1.12	0.45	0.04	2.33	1.66	XXX
92311		A	Contact lens fitting	1.08	1.09	0.35	0.03	2.20	1.46	XXX
92312		A	Contact lens fitting	1.26	1.08	0.50	0.03	2.37	1.79	XXX
92313		A	Contact lens fitting	0.92	1.06	0.29	0.02	2.00	1.23	XXX
92314		N	Prescription of contact lens	+0.69	0.94	0.27	0.01	1.64	0.97	XXX
92315		A	Prescription of contact lens	0.45	0.85	0.16	0.01	1.31	0.62	XXX
92316		A	Prescription of contact lens	0.68	0.91	0.29	0.02	1.61	0.99	XXX
92317		A	Prescription of contact lens	0.45	0.94	0.15	0.01	1.40	0.61	XXX
92325		A	Modification of contact lens	0.00	0.40	NA	0.01	0.41	NA	XXX
92326		A	Replacement of contact lens	0.00	1.63	NA	0.06	1.69	NA	XXX
92340		N	Fitting of spectacles	+0.37	0.70	0.14	0.01	1.08	0.52	XXX
92341		N	Fitting of spectacles	+0.47	0.74	0.18	0.01	1.22	0.66	XXX
92342		N	Fitting of spectacles	+0.53	0.76	0.21	0.01	1.30	0.75	XXX
92352		B	Special spectacles fitting	+0.37	0.68	0.14	0.01	1.06	0.52	XXX
92353		B	Special spectacles fitting	+0.50	0.73	0.19	0.02	1.25	0.71	XXX
92354		B	Special spectacles fitting	+0.00	8.89	NA	0.10	8.99	NA	XXX
92355		B	Special spectacles fitting	+0.00	4.34	NA	0.01	4.35	NA	XXX
92358		B	Eye prosthesis service	+0.00	0.97	NA	0.05	1.02	NA	XXX
92370		N	Repair & adjust spectacles	+0.32	0.55	0.13	0.02	0.89	0.47	XXX
92371		B	Repair & adjust spectacles	+0.00	0.62	NA	0.02	0.64	NA	XXX
92499	26	C	Eye service or procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
92499	TC	C	Eye service or procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92499	.....	C	Eye service or procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92502	.....	A	Ear and throat examination	1.51	NA	1.11	0.05	NA	2.67	000
92504	.....	A	Ear microscopy examination	0.18	0.50	0.09	0.01	0.69	0.28	XXX
92506	.....	A	Speech/hearing evaluation	0.86	2.60	0.40	0.03	3.49	1.29	XXX
92507	.....	A	Speech/hearing therapy	0.52	1.11	0.23	0.02	1.65	0.77	XXX
92508	.....	A	Speech/hearing therapy	0.26	0.51	0.12	0.01	0.78	0.39	XXX
92511	.....	A	Nasopharyngoscopy	0.84	3.32	0.78	0.03	4.19	1.65	000
92512	.....	A	Nasal function studies	0.55	1.14	0.18	0.02	1.71	0.75	XXX
92516	.....	A	Facial nerve function test	0.43	1.20	0.22	0.01	1.64	0.66	XXX
92520	.....	A	Laryngeal function studies	0.75	0.51	0.39	0.03	1.29	1.17	XXX
92526	.....	A	Oral function therapy	0.55	1.64	0.20	0.02	2.21	0.77	XXX
92531	.....	B	Spontaneous nystagmus study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92532	.....	B	Positional nystagmus test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92533	.....	B	Caloric vestibular test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92534	.....	B	Optokinetic nystagmus test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92541	26	A	Spontaneous nystagmus test	0.40	0.19	0.19	0.02	0.61	0.61	XXX
92541	TC	A	Spontaneous nystagmus test	0.00	0.84	NA	0.02	0.86	NA	XXX
92541	.....	A	Spontaneous nystagmus test	0.40	1.03	NA	0.04	1.47	NA	XXX
92542	26	A	Positional nystagmus test	0.33	0.16	0.16	0.01	0.50	0.50	XXX
92542	TC	A	Positional nystagmus test	0.00	0.98	NA	0.02	1.00	NA	XXX
92542	.....	A	Positional nystagmus test	0.33	1.14	NA	0.03	1.50	NA	XXX
92543	26	A	Caloric vestibular test	0.10	0.05	0.05	0.01	0.16	0.16	XXX
92543	TC	A	Caloric vestibular test	0.00	0.52	NA	0.01	0.53	NA	XXX
92543	.....	A	Caloric vestibular test	0.10	0.57	NA	0.02	0.69	NA	XXX
92544	26	A	Optokinetic nystagmus test	0.26	0.12	0.12	0.01	0.39	0.39	XXX
92544	TC	A	Optokinetic nystagmus test	0.00	0.78	NA	0.02	0.80	NA	XXX
92544	.....	A	Optokinetic nystagmus test	0.26	0.90	NA	0.03	1.19	NA	XXX
92545	26	A	Oscillating tracking test	0.23	0.11	0.11	0.01	0.35	0.35	XXX
92545	TC	A	Oscillating tracking test	0.00	0.69	NA	0.02	0.71	NA	XXX
92545	.....	A	Oscillating tracking test	0.23	0.80	NA	0.03	1.06	NA	XXX
92546	26	A	Sinusoidal rotational test	0.29	0.13	0.13	0.01	0.43	0.43	XXX
92546	TC	A	Sinusoidal rotational test	0.00	1.86	NA	0.02	1.88	NA	XXX
92546	.....	A	Sinusoidal rotational test	0.29	1.99	NA	0.03	2.31	NA	XXX
92547	.....	A	Supplemental electrical test	0.00	0.08	NA	0.06	0.14	NA	ZZZ
92548	26	A	Posturography	0.50	0.26	0.26	0.02	0.78	0.78	XXX
92548	TC	A	Posturography	0.00	2.00	NA	0.13	2.13	NA	XXX
92548	.....	A	Posturography	0.50	2.26	NA	0.15	2.91	NA	XXX
92551	.....	N	Pure tone hearing test, air	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92552	.....	A	Pure tone audiometry, air	0.00	0.44	NA	0.04	0.48	NA	XXX
92553	.....	A	Audiometry, air & bone	0.00	0.66	NA	0.06	0.72	NA	XXX
92555	.....	A	Speech threshold audiometry	0.00	0.38	NA	0.04	0.42	NA	XXX
92556	.....	A	Speech audiometry, complete	0.00	0.57	NA	0.06	0.63	NA	XXX
92557	.....	A	Comprehensive hearing test	0.00	1.19	NA	0.12	1.31	NA	XXX
92559	.....	N	Group audiometric testing	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92560	.....	N	Bekesy audiometry, screen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92561	.....	A	Bekesy audiometry, diagnosis	0.00	0.72	NA	0.06	0.78	NA	XXX
92562	.....	A	Loudness balance test	0.00	0.41	NA	0.04	0.45	NA	XXX
92563	.....	A	Tone decay hearing test	0.00	0.38	NA	0.04	0.42	NA	XXX
92564	.....	A	Sisi hearing test	0.00	0.47	NA	0.05	0.52	NA	XXX
92565	.....	A	Stenger test, pure tone	0.00	0.40	NA	0.04	0.44	NA	XXX
92567	.....	A	Tympanometry	0.00	0.52	NA	0.06	0.58	NA	XXX
92568	.....	A	Acoustic refl threshold tst	0.00	0.38	NA	0.04	0.42	NA	XXX
92569	.....	A	Acoustic reflex decay test	0.00	0.41	NA	0.04	0.45	NA	XXX
92571	.....	A	Filtered speech hearing test	0.00	0.39	NA	0.04	0.43	NA	XXX
92572	.....	A	Staggered spondaic word test	0.00	0.09	NA	0.01	0.10	NA	XXX
92573	.....	A	Lombard test	0.00	0.35	NA	0.04	0.39	NA	XXX
92575	.....	A	Sensorineural acuity test	0.00	0.30	NA	0.02	0.32	NA	XXX
92576	.....	A	Synthetic sentence test	0.00	0.44	NA	0.05	0.49	NA	XXX
92577	.....	A	Stenger test, speech	0.00	0.72	NA	0.07	0.79	NA	XXX
92579	.....	A	Visual audiometry (vra)	0.00	0.73	NA	0.06	0.79	NA	XXX
92582	.....	A	Conditioning play audiometry	0.00	0.73	NA	0.06	0.79	NA	XXX
92583	.....	A	Select picture audiometry	0.00	0.89	NA	0.08	0.97	NA	XXX
92584	.....	A	Electrocochleography	0.00	2.48	NA	0.21	2.69	NA	XXX
92585	26	A	Auditor evoke potent, compre	0.50	0.21	0.21	0.03	0.74	0.74	XXX
92585	TC	A	Auditor evoke potent, compre	0.00	1.86	NA	0.14	2.00	NA	XXX
92585	.....	A	Auditor evoke potent, compre	0.50	2.07	NA	0.17	2.74	NA	XXX
92586	.....	A	Auditor evoke potent, limit	0.00	1.86	NA	0.14	2.00	NA	XXX
92587	26	A	Evoked auditory test	0.13	0.06	0.06	0.01	0.20	0.20	XXX
92587	TC	A	Evoked auditory test	0.00	1.31	NA	0.11	1.42	NA	XXX
92587	.....	A	Evoked auditory test	0.13	1.37	NA	0.12	1.62	NA	XXX
92588	26	A	Evoked auditory test	0.36	0.16	0.16	0.01	0.53	0.53	XXX
92588	TC	A	Evoked auditory test	0.00	1.47	NA	0.13	1.60	NA	XXX
92588	.....	A	Evoked auditory test	0.36	1.63	NA	0.14	2.13	NA	XXX
92590	.....	N	Hearing aid exam, one ear	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
92591	.....	N	Hearing aid exam, both ears	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92592	.....	N	Hearing aid check, one ear	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92593	.....	N	Hearing aid check, both ears	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92594	.....	N	Electro hearng aid test, one	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92595	.....	N	Electro hearng aid tst, both	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92596	.....	A	Ear protector evaluation	0.00	0.59	NA	0.06	0.65	NA	XXX
92597	.....	A	Oral speech device eval	0.86	1.69	0.45	0.03	2.58	1.34	XXX
92601	.....	A	Cochlear implt f/up exam < 7	0.00	3.51	NA	0.07	3.58	NA	XXX
92602	.....	A	Reprogram cochlear implt < 7	0.00	2.39	NA	0.07	2.46	NA	XXX
92603	.....	A	Cochlear implt f/up exam 7 >	0.00	2.15	NA	0.07	2.22	NA	XXX
92604	.....	A	Reprogram cochlear implt 7 >	0.00	1.35	NA	0.07	1.42	NA	XXX
92605	.....	B	Eval for nonspeech device rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92606	.....	B	Non-speech device service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92607	.....	A	Ex for speech device rx, 1hr	0.00	3.09	NA	0.05	3.14	NA	XXX
92608	.....	A	Ex for speech device rx addl	0.00	0.55	NA	0.05	0.60	NA	XXX
92609	.....	A	Use of speech device service	0.00	1.59	NA	0.04	1.63	NA	XXX
92610	.....	A	Evaluate swallowing function	0.00	3.44	NA	0.08	3.52	NA	XXX
92611	.....	A	Motion fluoroscopy/swallow	0.00	3.44	NA	0.08	3.52	NA	XXX
92612	.....	A	Endoscopy swallow tst (fees)	1.27	2.75	0.66	0.04	4.06	1.97	XXX
92613	.....	A	Endoscopy swallow tst (fees)	0.71	0.40	0.39	0.05	1.16	1.15	XXX
92614	.....	A	Laryngoscopic sensory test	1.27	2.51	0.66	0.04	3.82	1.97	XXX
92615	.....	A	Eval laryngoscopy sense tst	0.63	0.35	0.35	0.05	1.03	1.03	XXX
92616	.....	A	Fees w/laryngeal sense test	1.88	3.40	0.99	0.06	5.34	2.93	XXX
92617	.....	A	Interprt fees/laryngeal test	0.79	0.44	0.44	0.05	1.28	1.28	XXX
92620	.....	A	Auditory function, 60 min	0.00	1.14	NA	0.06	1.20	NA	XXX
92621	.....	A	Auditory function, + 15 min	0.00	0.25	NA	0.06	0.31	NA	ZZZ
92625	.....	A	Tinnitus assessment	0.00	1.12	NA	0.06	1.18	NA	XXX
92626	.....	A	Eval aud rehab status	0.00	0.55	NA	0.06	0.61	NA	XXX
92627	.....	A	Eval aud status rehab add-on	0.00	0.55	NA	0.06	0.61	NA	XXX
92630	.....	I	Aud rehab pre-ling hear loss	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92633	.....	I	Aud rehab postling hear loss	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92700	.....	C	Ent procedure/service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92950	.....	A	Heart/lung resuscitation cpr	3.79	4.21	0.97	0.28	8.28	5.04	000
92953	.....	A	Temporary external pacing	0.23	NA	0.07	0.02	NA	0.32	000
92960	.....	A	Cardioversion electric, ext	2.25	6.33	1.17	0.07	8.65	3.49	000
92961	.....	A	Cardioversion, electric, int	4.59	NA	2.09	0.29	NA	6.97	000
92970	.....	A	Cardioassist, internal	3.51	NA	1.06	0.16	NA	4.73	000
92971	.....	A	Cardioassist, external	1.77	NA	0.85	0.06	NA	2.68	000
92973	.....	A	Percut coronary thrombectomy	3.28	NA	1.29	0.23	NA	4.80	ZZZ
92974	.....	A	Cath place, cardio brachytx	3.00	NA	1.18	0.21	NA	4.39	ZZZ
92975	.....	A	Dissolve clot, heart vessel	7.24	NA	2.82	0.50	NA	10.56	000
92977	.....	A	Dissolve clot, heart vessel	0.00	8.07	NA	0.46	8.53	NA	XXX
92978	26	A	Intravasc us, heart add-on	1.80	0.71	0.71	0.06	2.57	2.57	ZZZ
92978	TC	A	Intravasc us, heart add-on	0.00	4.57	NA	0.24	4.81	NA	ZZZ
92978	.....	A	Intravasc us, heart add-on	1.80	5.28	NA	0.30	7.38	NA	ZZZ
92979	26	A	Intravasc us, heart add-on	1.44	0.56	0.56	0.06	2.06	2.06	ZZZ
92979	TC	A	Intravasc us, heart add-on	0.00	2.30	NA	0.13	2.43	NA	ZZZ
92979	.....	A	Intravasc us, heart add-on	1.44	2.86	NA	0.19	4.49	NA	ZZZ
92980	.....	A	Insert intracoronary stent	14.82	NA	6.07	1.03	NA	21.92	000
92981	.....	A	Insert intracoronary stent	4.16	NA	1.63	0.29	NA	6.08	ZZZ
92982	.....	A	Coronary artery dilation	10.96	NA	4.54	0.76	NA	16.26	000
92984	.....	A	Coronary artery dilation	2.97	NA	1.16	0.21	NA	4.34	ZZZ
92986	.....	A	Revision of aortic valve	21.77	NA	11.86	1.51	NA	35.14	090
92987	.....	A	Revision of mitral valve	22.67	NA	12.25	1.59	NA	36.51	090
92990	.....	A	Revision of pulmonary valve	17.31	NA	9.82	1.20	NA	28.33	090
92992	.....	C	Revision of heart chamber	0.00	0.00	0.00	0.00	0.00	0.00	090
92993	.....	C	Revision of heart chamber	0.00	0.00	0.00	0.00	0.00	0.00	090
92995	.....	A	Coronary atherectomy	12.07	NA	4.97	0.84	NA	17.88	000
92996	.....	A	Coronary atherectomy add-on	3.26	NA	1.27	0.10	NA	4.63	ZZZ
92997	.....	A	Pul art balloon repr, percut	11.98	NA	4.83	0.40	NA	17.21	000
92998	.....	A	Pul art balloon repr, percut	5.99	NA	2.21	0.28	NA	8.48	ZZZ
93000	.....	A	Electrocardiogram, complete	0.17	0.51	NA	0.03	0.71	NA	XXX
93005	.....	A	Electrocardiogram, tracing	0.00	0.45	NA	0.02	0.47	NA	XXX
93010	.....	A	Electrocardiogram report	0.17	0.06	0.06	0.01	0.24	0.24	XXX
93012	.....	A	Transmission of ecg	0.00	6.03	NA	0.18	6.21	NA	XXX
93014	.....	A	Report on transmitted ecg	0.52	0.19	0.19	0.02	0.73	0.73	XXX
93015	.....	A	Cardiovascular stress test	0.75	1.96	NA	0.14	2.85	NA	XXX
93016	.....	A	Cardiovascular stress test	0.45	0.17	0.17	0.02	0.64	0.64	XXX
93017	.....	A	Cardiovascular stress test	0.00	1.68	NA	0.11	1.79	NA	XXX
93018	.....	A	Cardiovascular stress test	0.30	0.11	0.11	0.01	0.42	0.42	XXX
93024	26	A	Cardiac drug stress test	1.17	0.45	0.45	0.04	1.66	1.66	XXX
93024	TC	A	Cardiac drug stress test	0.00	1.12	NA	0.08	1.20	NA	XXX
93024	.....	A	Cardiac drug stress test	1.17	1.57	NA	0.12	2.86	NA	XXX
93025	26	A	Microvolt t-wave assess	0.75	0.29	0.29	0.03	1.07	1.07	XXX
93025	TC	A	Microvolt t-wave assess	0.00	7.32	NA	0.11	7.43	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
93025	.....	A	Microvolt t-wave assess	0.75	7.61	NA	0.14	8.50	NA	XXX
93040	.....	A	Rhythm ECG with report	0.16	0.20	NA	0.02	0.38	NA	XXX
93041	.....	A	Rhythm ECG, tracing	0.00	0.15	NA	0.01	0.16	NA	XXX
93042	.....	A	Rhythm ECG, report	0.16	0.05	0.05	0.01	0.22	0.22	XXX
93224	.....	A	ECG monitor/report, 24 hrs	0.52	3.62	NA	0.24	4.38	NA	XXX
93225	.....	A	ECG monitor/record, 24 hrs	0.00	1.24	NA	0.08	1.32	NA	XXX
93226	.....	A	ECG monitor/report, 24 hrs	0.00	2.19	NA	0.14	2.33	NA	XXX
93227	.....	A	ECG monitor/review, 24 hrs	0.52	0.19	0.19	0.02	0.73	0.73	XXX
93230	.....	A	ECG monitor/report, 24 hrs	0.52	3.90	NA	0.26	4.68	NA	XXX
93231	.....	A	Ecg monitor/record, 24 hrs	0.00	1.52	NA	0.11	1.63	NA	XXX
93232	.....	A	ECG monitor/report, 24 hrs	0.00	2.19	NA	0.13	2.32	NA	XXX
93233	.....	A	ECG monitor/review, 24 hrs	0.52	0.19	0.19	0.02	0.73	0.73	XXX
93235	.....	A	ECG monitor/report, 24 hrs	0.45	2.79	NA	0.16	3.40	NA	XXX
93236	.....	A	ECG monitor/report, 24 hrs	0.00	2.63	NA	0.14	2.77	NA	XXX
93237	.....	A	ECG monitor/review, 24 hrs	0.45	0.16	0.16	0.02	0.63	0.63	XXX
93268	.....	A	ECG record/review	0.52	7.46	NA	0.28	8.26	NA	XXX
93270	.....	A	ECG recording	0.00	1.24	NA	0.08	1.32	NA	XXX
93271	.....	A	Ecg/monitoring and analysis	0.00	6.03	NA	0.18	6.21	NA	XXX
93272	.....	A	Ecg/review, interpret only	0.52	0.19	0.19	0.02	0.73	0.73	XXX
93278	26	A	ECG/signal-averaged	0.25	0.10	0.10	0.01	0.36	0.36	XXX
93278	TC	A	ECG/signal-averaged	0.00	1.15	NA	0.11	1.26	NA	XXX
93278	.....	A	ECG/signal-averaged	0.25	1.25	NA	0.12	1.62	NA	XXX
93303	26	A	Echo transthoracic	1.30	0.48	0.48	0.04	1.82	1.82	XXX
93303	TC	A	Echo transthoracic	0.00	3.87	NA	0.23	4.10	NA	XXX
93303	.....	A	Echo transthoracic	1.30	4.35	NA	0.27	5.92	NA	XXX
93304	26	A	Echo transthoracic	0.75	0.28	0.28	0.02	1.05	1.05	XXX
93304	TC	A	Echo transthoracic	0.00	1.95	NA	0.13	2.08	NA	XXX
93304	.....	A	Echo transthoracic	0.75	2.23	NA	0.15	3.13	NA	XXX
93307	26	A	Echo exam of heart	0.92	0.35	0.35	0.03	1.30	1.30	XXX
93307	TC	A	Echo exam of heart	0.00	3.87	NA	0.23	4.10	NA	XXX
93307	.....	A	Echo exam of heart	0.92	4.22	NA	0.26	5.40	NA	XXX
93308	26	A	Echo exam of heart	0.53	0.20	0.20	0.02	0.75	0.75	XXX
93308	TC	A	Echo exam of heart	0.00	1.95	NA	0.13	2.08	NA	XXX
93308	.....	A	Echo exam of heart	0.53	2.15	NA	0.15	2.83	NA	XXX
93312	26	A	Echo transesophageal	2.20	0.79	0.79	0.08	3.07	3.07	XXX
93312	TC	A	Echo transesophageal	0.00	3.79	NA	0.29	4.08	NA	XXX
93312	.....	A	Echo transesophageal	2.20	4.58	NA	0.37	7.15	NA	XXX
93313	.....	A	Echo transesophageal	0.95	NA	0.21	0.06	NA	1.22	XXX
93314	26	A	Echo transesophageal	1.25	0.47	0.47	0.04	1.76	1.76	XXX
93314	TC	A	Echo transesophageal	0.00	3.79	NA	0.29	4.08	NA	XXX
93314	.....	A	Echo transesophageal	1.25	4.26	NA	0.33	5.84	NA	XXX
93315	26	A	Echo transesophageal	2.78	1.01	1.01	0.09	3.88	3.88	XXX
93315	TC	C	Echo transesophageal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93315	.....	C	Echo transesophageal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93316	.....	A	Echo transesophageal	0.95	NA	0.24	0.05	NA	1.24	XXX
93317	26	A	Echo transesophageal	1.83	0.67	0.67	0.08	2.58	2.58	XXX
93317	TC	C	Echo transesophageal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93317	.....	C	Echo transesophageal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93318	26	A	Echo transesophageal intraop	2.20	0.48	0.48	0.14	2.82	2.82	XXX
93318	TC	C	Echo transesophageal intraop	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93318	.....	C	Echo transesophageal intraop	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93320	26	A	Doppler echo exam, heart	0.38	0.15	0.15	0.01	0.54	0.54	ZZZ
93320	TC	A	Doppler echo exam, heart	0.00	1.71	NA	0.12	1.83	NA	ZZZ
93320	.....	A	Doppler echo exam, heart	0.38	1.86	NA	0.13	2.37	NA	ZZZ
93321	26	A	Doppler echo exam, heart	0.15	0.06	0.06	0.01	0.22	0.22	ZZZ
93321	TC	A	Doppler echo exam, heart	0.00	1.11	NA	0.08	1.19	NA	ZZZ
93321	.....	A	Doppler echo exam, heart	0.15	1.17	NA	0.09	1.41	NA	ZZZ
93325	26	A	Doppler color flow add-on	0.07	0.03	0.03	0.01	0.11	0.11	ZZZ
93325	TC	A	Doppler color flow add-on	0.00	2.91	NA	0.21	3.12	NA	ZZZ
93325	.....	A	Doppler color flow add-on	0.07	2.94	NA	0.22	3.23	NA	ZZZ
93350	26	A	Echo transthoracic	1.48	0.57	0.57	0.05	2.10	2.10	XXX
93350	TC	A	Echo transthoracic	0.00	1.77	NA	0.13	1.90	NA	XXX
93350	.....	A	Echo transthoracic	1.48	2.34	NA	0.18	4.00	NA	XXX
93501	26	A	Right heart catheterization	3.02	1.15	1.15	0.21	4.38	4.38	000
93501	TC	A	Right heart catheterization	0.00	16.95	NA	1.05	18.00	NA	000
93501	.....	A	Right heart catheterization	3.02	18.10	NA	1.26	22.38	NA	000
93503	.....	A	Insert/place heart catheter	2.91	NA	0.68	0.20	NA	3.79	000
93505	26	A	Biopsy of heart lining	4.37	1.68	1.68	0.30	6.35	6.35	000
93505	TC	A	Biopsy of heart lining	0.00	1.99	NA	0.16	2.15	NA	000
93505	.....	A	Biopsy of heart lining	4.37	3.67	NA	0.46	8.50	NA	000
93508	26	A	Cath placement, angiography	4.09	2.09	2.09	0.28	6.46	6.46	000
93508	TC	A	Cath placement, angiography	0.00	12.64	NA	0.65	13.29	NA	000
93508	.....	A	Cath placement, angiography	4.09	14.73	NA	0.93	19.75	NA	000
93510	26	A	Left heart catheterization	4.32	2.18	2.18	0.30	6.80	6.80	000
93510	TC	A	Left heart catheterization	0.00	37.06	NA	2.31	39.37	NA	000

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
93510	.....	A	Left heart catheterization	4.32	39.24	NA	2.61	46.17	NA	000
93511	26	A	Left heart catheterization	5.02	2.45	2.45	0.35	7.82	7.82	000
93511	TC	A	Left heart catheterization	0.00	36.07	NA	2.24	38.31	NA	000
93511	.....	A	Left heart catheterization	5.02	38.52	NA	2.59	46.13	NA	000
93514	26	A	Left heart catheterization	7.04	3.13	3.13	0.49	10.66	10.66	000
93514	TC	C	Left heart catheterization	0.00	0.00	0.00	0.00	0.00	0.00	000
93514	.....	R	Left heart catheterization	7.04	39.09	39.09	2.74	48.87	48.87	000
93524	26	A	Left heart catheterization	6.94	3.18	3.18	0.48	10.60	10.60	000
93524	TC	A	Left heart catheterization	0.00	47.14	NA	2.95	50.09	NA	000
93524	.....	A	Left heart catheterization	6.94	50.32	NA	3.43	60.69	NA	000
93526	26	A	Rt & Lt heart catheters	5.98	2.82	2.82	0.42	9.22	9.22	000
93526	TC	A	Rt & Lt heart catheters	0.00	48.43	NA	3.04	51.47	NA	000
93526	.....	A	Rt & Lt heart catheters	5.98	51.25	NA	3.46	60.69	NA	000
93527	26	A	Rt & Lt heart catheters	7.27	3.32	3.32	0.51	11.10	11.10	000
93527	TC	A	Rt & Lt heart catheters	0.00	47.14	NA	2.95	50.09	NA	000
93527	.....	A	Rt & Lt heart catheters	7.27	50.46	NA	3.46	61.19	NA	000
93528	26	A	Rt & Lt heart catheters	8.99	4.04	4.04	0.62	13.65	13.65	000
93528	TC	A	Rt & Lt heart catheters	0.00	47.14	NA	2.95	50.09	NA	000
93528	.....	A	Rt & Lt heart catheters	8.99	51.18	NA	3.57	63.74	NA	000
93529	26	A	Rt, lt heart catheterization	4.79	2.28	2.28	0.33	7.40	7.40	000
93529	TC	A	Rt, lt heart catheterization	0.00	47.14	NA	2.95	50.09	NA	000
93529	.....	A	Rt, lt heart catheterization	4.79	49.42	NA	3.28	57.49	NA	000
93530	26	A	Rt heart cath, congenital	4.22	1.94	1.94	0.29	6.45	6.45	000
93530	TC	A	Rt heart cath, congenital	0.00	16.95	NA	1.05	18.00	NA	000
93530	.....	A	Rt heart cath, congenital	4.22	18.89	NA	1.34	24.45	NA	000
93531	26	A	R & l heart cath, congenital	8.34	3.59	3.59	0.58	12.51	12.51	000
93531	TC	A	R & l heart cath, congenital	0.00	48.43	NA	3.04	51.47	NA	000
93531	.....	A	R & l heart cath, congenital	8.34	52.02	NA	3.62	63.98	NA	000
93532	26	A	R & l heart cath, congenital	9.99	4.26	4.26	0.69	14.94	14.94	000
93532	TC	C	R & l heart cath, congenital	0.00	0.00	0.00	0.00	0.00	0.00	000
93532	.....	C	R & l heart cath, congenital	0.00	0.00	0.00	0.00	0.00	0.00	000
93533	26	A	R & l heart cath, congenital	6.69	2.80	2.80	0.47	9.96	9.96	000
93533	TC	C	R & l heart cath, congenital	0.00	0.00	0.00	0.00	0.00	0.00	000
93533	.....	C	R & l heart cath, congenital	0.00	0.00	0.00	0.00	0.00	0.00	000
93539	.....	A	Injection, cardiac cath	0.40	NA	0.16	0.01	NA	0.57	000
93540	.....	A	Injection, cardiac cath	0.43	NA	0.17	0.01	NA	0.61	000
93541	.....	A	Injection for lung angiogram	0.29	NA	0.11	0.01	NA	0.41	000
93542	.....	A	Injection for heart x-rays	0.29	NA	0.11	0.01	NA	0.41	000
93543	.....	A	Injection for heart x-rays	0.29	NA	0.11	0.01	NA	0.41	000
93544	.....	A	Injection for aortography	0.25	NA	0.10	0.01	NA	0.36	000
93545	.....	A	Inject for coronary x-rays	0.40	NA	0.16	0.01	NA	0.57	000
93555	26	A	Imaging, cardiac cath	0.81	0.32	0.32	0.03	1.16	1.16	XXX
93555	TC	A	Imaging, cardiac cath	0.00	6.29	NA	0.34	6.63	NA	XXX
93555	.....	A	Imaging, cardiac cath	0.81	6.61	NA	0.37	7.79	NA	XXX
93556	26	A	Imaging, cardiac cath	0.83	0.32	0.32	0.03	1.18	1.18	XXX
93556	TC	A	Imaging, cardiac cath	0.00	9.92	NA	0.51	10.43	NA	XXX
93556	.....	A	Imaging, cardiac cath	0.83	10.24	NA	0.54	11.61	NA	XXX
93561	26	A	Cardiac output measurement	0.50	0.16	0.16	0.02	0.68	0.68	000
93561	TC	A	Cardiac output measurement	0.00	0.52	NA	0.06	0.58	NA	000
93561	.....	A	Cardiac output measurement	0.50	0.68	NA	0.08	1.26	NA	000
93562	26	A	Cardiac output measurement	0.16	0.05	0.05	0.01	0.22	0.22	000
93562	TC	A	Cardiac output measurement	0.00	0.32	NA	0.04	0.36	NA	000
93562	.....	A	Cardiac output measurement	0.16	0.37	NA	0.05	0.58	NA	000
93571	26	A	Heart flow reserve measure	1.80	0.68	0.68	0.06	2.54	2.54	ZZZ
93571	TC	A	Heart flow reserve measure	0.00	4.57	NA	0.24	4.81	NA	ZZZ
93571	.....	A	Heart flow reserve measure	1.80	5.25	NA	0.30	7.35	NA	ZZZ
93572	26	A	Heart flow reserve measure	1.44	0.50	0.50	0.04	1.98	1.98	ZZZ
93572	TC	C	Heart flow reserve measure	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
93572	.....	C	Heart flow reserve measure	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
93580	.....	A	Transcath closure of asd	17.97	NA	7.40	1.25	NA	26.62	000
93581	.....	A	Transcath closure of vsd	24.39	NA	9.42	1.71	NA	35.52	000
93600	26	A	Bundle of His recording	2.12	0.83	0.83	0.16	3.11	3.11	000
93600	TC	A	Bundle of His recording	0.00	1.96	NA	0.13	2.09	NA	000
93600	.....	A	Bundle of His recording	2.12	2.79	NA	0.29	5.20	NA	000
93602	26	A	Intra-atrial recording	2.12	0.82	0.82	0.17	3.11	3.11	000
93602	TC	A	Intra-atrial recording	0.00	1.11	NA	0.07	1.18	NA	000
93602	.....	A	Intra-atrial recording	2.12	1.93	NA	0.24	4.29	NA	000
93603	26	A	Right ventricular recording	2.12	0.81	0.81	0.18	3.11	3.11	000
93603	TC	A	Right ventricular recording	0.00	1.68	NA	0.11	1.79	NA	000
93603	.....	A	Right ventricular recording	2.12	2.49	NA	0.29	4.90	NA	000
93609	26	A	Map tachycardia, add-on	4.99	1.96	1.96	0.35	7.30	7.30	ZZZ
93609	TC	A	Map tachycardia, add-on	0.00	2.73	NA	0.17	2.90	NA	ZZZ
93609	.....	A	Map tachycardia, add-on	4.99	4.69	NA	0.52	10.20	NA	ZZZ
93610	26	A	Intra-atrial pacing	3.02	1.16	1.16	0.24	4.42	4.42	000
93610	TC	A	Intra-atrial pacing	0.00	1.35	NA	0.10	1.45	NA	000

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
93610	.....	A	Intra-atrial pacing	3.02	2.51	NA	0.34	5.87	NA	000
93612	26	A	Intraventricular pacing	3.02	1.16	1.16	0.25	4.43	4.43	000
93612	TC	A	Intraventricular pacing	0.00	1.61	NA	0.11	1.72	NA	000
93612	.....	A	Intraventricular pacing	3.02	2.77	NA	0.36	6.15	NA	000
93613	.....	A	Electrophys map 3d, add-on	6.99	NA	2.77	0.49	NA	10.25	ZZZ
93615	26	A	Esophageal recording	0.99	0.27	0.27	0.03	1.29	1.29	000
93615	TC	A	Esophageal recording	0.00	0.32	NA	0.02	0.34	NA	000
93615	.....	A	Esophageal recording	0.99	0.59	NA	0.05	1.63	NA	000
93616	26	A	Esophageal recording	1.49	0.43	0.43	0.09	2.01	2.01	000
93616	TC	C	Esophageal recording	0.00	0.00	0.00	0.00	0.00	0.00	000
93616	.....	C	Esophageal recording	0.00	0.00	0.00	0.00	0.00	0.00	000
93618	26	A	Heart rhythm pacing	4.25	1.67	1.67	0.30	6.22	6.22	000
93618	TC	A	Heart rhythm pacing	0.00	3.97	NA	0.24	4.21	NA	000
93618	.....	A	Heart rhythm pacing	4.25	5.64	NA	0.54	10.43	NA	000
93619	26	A	Electrophysiology evaluation	7.31	3.19	3.19	0.51	11.01	11.01	000
93619	TC	A	Electrophysiology evaluation	0.00	7.72	NA	0.47	8.19	NA	000
93619	.....	A	Electrophysiology evaluation	7.31	10.91	NA	0.98	19.20	NA	000
93620	26	A	Electrophysiology evaluation	11.57	4.85	4.85	0.80	17.22	17.22	000
93620	TC	C	Electrophysiology evaluation	0.00	0.00	0.00	0.00	0.00	0.00	000
93620	.....	C	Electrophysiology evaluation	0.00	0.00	0.00	0.00	0.00	0.00	000
93621	26	A	Electrophysiology evaluation	2.10	0.82	0.82	0.15	3.07	3.07	ZZZ
93621	TC	C	Electrophysiology evaluation	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
93621	.....	C	Electrophysiology evaluation	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
93622	26	A	Electrophysiology evaluation	3.10	1.21	1.21	0.22	4.53	4.53	ZZZ
93622	TC	C	Electrophysiology evaluation	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
93622	.....	C	Electrophysiology evaluation	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
93623	26	A	Stimulation, pacing heart	2.85	1.11	1.11	0.20	4.16	4.16	ZZZ
93623	TC	C	Stimulation, pacing heart	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
93623	.....	C	Stimulation, pacing heart	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
93624	26	A	Electrophysiologic study	4.80	2.20	2.20	0.33	7.33	7.33	000
93624	TC	A	Electrophysiologic study	0.00	1.99	NA	0.13	2.12	NA	000
93624	.....	A	Electrophysiologic study	4.80	4.19	NA	0.46	9.45	NA	000
93631	26	A	Heart pacing, mapping	7.59	2.78	2.78	0.97	11.34	11.34	000
93631	TC	C	Heart pacing, mapping	0.00	0.00	0.00	0.00	0.00	0.00	000
93631	.....	C	Heart pacing, mapping	0.00	0.00	0.00	0.00	0.00	0.00	000
93640	26	A	Evaluation heart device	3.51	1.36	1.36	0.24	5.11	5.11	000
93640	TC	A	Evaluation heart device	0.00	7.19	NA	0.42	7.61	NA	000
93640	.....	A	Evaluation heart device	3.51	8.55	NA	0.66	12.72	NA	000
93641	26	A	Electrophysiology evaluation	5.92	2.32	2.32	0.41	8.65	8.65	000
93641	TC	A	Electrophysiology evaluation	0.00	7.19	NA	0.42	7.61	NA	000
93641	.....	A	Electrophysiology evaluation	5.92	9.51	NA	0.83	16.26	NA	000
93642	26	A	Electrophysiology evaluation	4.88	2.22	2.22	0.15	7.25	7.25	000
93642	TC	A	Electrophysiology evaluation	0.00	7.19	NA	0.42	7.61	NA	000
93642	.....	A	Electrophysiology evaluation	4.88	9.41	NA	0.57	14.86	NA	000
93650	.....	A	Ablate heart dysrhythm focus	10.49	NA	4.44	0.73	NA	15.66	000
93651	.....	A	Ablate heart dysrhythm focus	16.23	NA	6.34	1.13	NA	23.70	000
93652	.....	A	Ablate heart dysrhythm focus	17.65	NA	6.90	1.23	NA	25.78	000
93660	26	A	Tilt table evaluation	1.89	0.74	0.74	0.06	2.69	2.69	000
93660	TC	A	Tilt table evaluation	0.00	1.68	NA	0.02	1.70	NA	000
93660	.....	A	Tilt table evaluation	1.89	2.42	NA	0.08	4.39	NA	000
93662	26	A	Intracardiac ecg (ice)	2.80	1.11	1.11	0.09	4.00	4.00	ZZZ
93662	TC	C	Intracardiac ecg (ice)	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
93662	.....	C	Intracardiac ecg (ice)	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
93668	.....	N	Peripheral vascular rehab	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93701	26	A	Bioimpedance, thoracic	0.17	0.07	0.07	0.01	0.25	0.25	XXX
93701	TC	A	Bioimpedance, thoracic	0.00	0.91	NA	0.01	0.92	NA	XXX
93701	.....	A	Bioimpedance, thoracic	0.17	0.98	NA	0.02	1.17	NA	XXX
93720	.....	A	Total body plethysmography	0.17	0.76	NA	0.07	1.00	NA	XXX
93721	.....	A	Plethysmography tracing	0.00	0.71	NA	0.06	0.77	NA	XXX
93722	.....	A	Plethysmography report	0.17	0.05	0.05	0.01	0.23	0.23	XXX
93724	26	A	Analyze pacemaker system	4.88	1.92	1.92	0.15	6.95	6.95	000
93724	TC	A	Analyze pacemaker system	0.00	3.97	NA	0.24	4.21	NA	000
93724	.....	A	Analyze pacemaker system	4.88	5.89	NA	0.39	11.16	NA	000
93727	.....	A	Analyze ilr system	0.52	0.20	0.20	0.02	0.74	0.74	XXX
93731	26	A	Analyze pacemaker system	0.45	0.17	0.17	0.01	0.63	0.63	XXX
93731	TC	A	Analyze pacemaker system	0.00	0.49	NA	0.04	0.53	NA	XXX
93731	.....	A	Analyze pacemaker system	0.45	0.66	NA	0.05	1.16	NA	XXX
93732	26	A	Analyze pacemaker system	0.92	0.35	0.35	0.03	1.30	1.30	XXX
93732	TC	A	Analyze pacemaker system	0.00	0.51	NA	0.04	0.55	NA	XXX
93732	.....	A	Analyze pacemaker system	0.92	0.86	NA	0.07	1.85	NA	XXX
93733	26	A	Telephone analy, pacemaker	0.17	0.07	0.07	0.01	0.25	0.25	XXX
93733	TC	A	Telephone analy, pacemaker	0.00	0.73	NA	0.06	0.79	NA	XXX
93733	.....	A	Telephone analy, pacemaker	0.17	0.80	NA	0.07	1.04	NA	XXX
93734	26	A	Analyze pacemaker system	0.38	0.15	0.15	0.01	0.54	0.54	XXX
93734	TC	A	Analyze pacemaker system	0.00	0.35	NA	0.02	0.37	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
93734	.....	A	Analyze pacemaker system	0.38	0.50	NA	0.03	0.91	NA	XXX
93735	26	A	Analyze pacemaker system	0.74	0.28	0.28	0.02	1.04	1.04	XXX
93735	TC	A	Analyze pacemaker system	0.00	0.44	NA	0.04	0.48	NA	XXX
93735	.....	A	Analyze pacemaker system	0.74	0.72	NA	0.06	1.52	NA	XXX
93736	26	A	Telephonic analy, pacemaker	0.15	0.06	0.06	0.01	0.22	0.22	XXX
93736	TC	A	Telephonic analy, pacemaker	0.00	0.63	NA	0.06	0.69	NA	XXX
93736	.....	A	Telephonic analy, pacemaker	0.15	0.69	NA	0.07	0.91	NA	XXX
93740	26	B	Temperature gradient studies	+0.16	0.04	0.04	0.01	0.21	0.21	XXX
93740	TC	B	Temperature gradient studies	+0.00	0.15	NA	0.01	0.16	NA	XXX
93740	.....	B	Temperature gradient studies	+0.16	0.19	NA	0.02	0.37	NA	XXX
93741	26	A	Analyze ht pace device sngl	0.80	0.31	0.31	0.03	1.14	1.14	XXX
93741	TC	A	Analyze ht pace device sngl	0.00	0.67	NA	0.04	0.71	NA	XXX
93741	.....	A	Analyze ht pace device sngl	0.80	0.98	NA	0.07	1.85	NA	XXX
93742	26	A	Analyze ht pace device sngl	0.91	0.36	0.36	0.03	1.30	1.30	XXX
93742	TC	A	Analyze ht pace device sngl	0.00	0.67	NA	0.04	0.71	NA	XXX
93742	.....	A	Analyze ht pace device sngl	0.91	1.03	NA	0.07	2.01	NA	XXX
93743	26	A	Analyze ht pace device dual	1.03	0.40	0.40	0.03	1.46	1.46	XXX
93743	TC	A	Analyze ht pace device dual	0.00	0.73	NA	0.04	0.77	NA	XXX
93743	.....	A	Analyze ht pace device dual	1.03	1.13	NA	0.07	2.23	NA	XXX
93744	26	A	Analyze ht pace device dual	1.18	0.46	0.46	0.04	1.68	1.68	XXX
93744	TC	A	Analyze ht pace device dual	0.00	0.67	NA	0.04	0.71	NA	XXX
93744	.....	A	Analyze ht pace device dual	1.18	1.13	NA	0.08	2.39	NA	XXX
93745	26	C	Set-up cardiovert-defibrill	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93745	TC	C	Set-up cardiovert-defibrill	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93745	.....	C	Set-up cardiovert-defibrill	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93760	.....	N	Cephalic thermogram	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93762	.....	N	Peripheral thermogram	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93770	26	B	Measure venous pressure	+0.16	0.05	0.05	0.01	0.22	0.22	XXX
93770	TC	B	Measure venous pressure	+0.00	0.03	NA	0.01	0.04	NA	XXX
93770	.....	B	Measure venous pressure	+0.16	0.08	NA	0.02	0.26	NA	XXX
93784	.....	A	Ambulatory BP monitoring	0.38	1.55	NA	0.03	1.96	NA	XXX
93786	.....	A	Ambulatory BP recording	0.00	0.91	NA	0.01	0.92	NA	XXX
93788	.....	A	Ambulatory BP analysis	0.00	0.51	NA	0.01	0.52	NA	XXX
93790	.....	A	Review/report BP recording	0.38	0.13	0.13	0.01	0.52	0.52	XXX
93797	.....	A	Cardiac rehab	0.18	0.30	0.07	0.01	0.49	0.26	000
93798	.....	A	Cardiac rehab/monitor	0.28	0.46	0.11	0.01	0.75	0.40	000
93799	26	C	Cardiovascular procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93799	TC	C	Cardiovascular procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93799	.....	C	Cardiovascular procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93875	26	A	Extracranial study	0.22	0.08	0.08	0.01	0.31	0.31	XXX
93875	TC	A	Extracranial study	0.00	2.26	NA	0.11	2.37	NA	XXX
93875	.....	A	Extracranial study	0.22	2.34	NA	0.12	2.68	NA	XXX
93880	26	A	Extracranial study	0.60	0.20	0.20	0.04	0.84	0.84	XXX
93880	TC	A	Extracranial study	0.00	5.37	NA	0.35	5.72	NA	XXX
93880	.....	A	Extracranial study	0.60	5.57	NA	0.39	6.56	NA	XXX
93882	26	A	Extracranial study	0.40	0.14	0.14	0.04	0.58	0.58	XXX
93882	TC	A	Extracranial study	0.00	3.37	NA	0.22	3.59	NA	XXX
93882	.....	A	Extracranial study	0.40	3.51	NA	0.26	4.17	NA	XXX
93886	26	A	Intracranial study	0.94	0.37	0.37	0.06	1.37	1.37	XXX
93886	TC	A	Intracranial study	0.00	6.39	NA	0.39	6.78	NA	XXX
93886	.....	A	Intracranial study	0.94	6.76	NA	0.45	8.15	NA	XXX
93888	26	A	Intracranial study	0.62	0.23	0.23	0.05	0.90	0.90	XXX
93888	TC	A	Intracranial study	0.00	4.02	NA	0.27	4.29	NA	XXX
93888	.....	A	Intracranial study	0.62	4.25	NA	0.32	5.19	NA	XXX
93890	26	A	Tcd, vasoreactivity study	1.00	0.40	0.40	0.06	1.46	1.46	XXX
93890	TC	A	Tcd, vasoreactivity study	0.00	4.51	NA	0.39	4.90	NA	XXX
93890	.....	A	Tcd, vasoreactivity study	1.00	4.91	NA	0.45	6.36	NA	XXX
93892	26	A	Tcd, emboli detect w/o inj	1.15	0.46	0.46	0.06	1.67	1.67	XXX
93892	TC	A	Tcd, emboli detect w/o inj	0.00	4.71	NA	0.39	5.10	NA	XXX
93892	.....	A	Tcd, emboli detect w/o inj	1.15	5.17	NA	0.45	6.77	NA	XXX
93893	26	A	Tcd, emboli detect w/inj	1.15	0.46	0.46	0.06	1.67	1.67	XXX
93893	TC	A	Tcd, emboli detect w/inj	0.00	4.58	NA	0.39	4.97	NA	XXX
93893	.....	A	Tcd, emboli detect w/inj	1.15	5.04	NA	0.45	6.64	NA	XXX
93922	26	A	Extremity study	0.25	0.08	0.08	0.02	0.35	0.35	XXX
93922	TC	A	Extremity study	0.00	2.61	NA	0.13	2.74	NA	XXX
93922	.....	A	Extremity study	0.25	2.69	NA	0.15	3.09	NA	XXX
93923	26	A	Extremity study	0.45	0.15	0.15	0.04	0.64	0.64	XXX
93923	TC	A	Extremity study	0.00	3.89	NA	0.22	4.11	NA	XXX
93923	.....	A	Extremity study	0.45	4.04	NA	0.26	4.75	NA	XXX
93924	26	A	Extremity study	0.50	0.17	0.17	0.05	0.72	0.72	XXX
93924	TC	A	Extremity study	0.00	4.63	NA	0.25	4.88	NA	XXX
93924	.....	A	Extremity study	0.50	4.80	NA	0.30	5.60	NA	XXX
93925	26	A	Lower extremity study	0.58	0.20	0.20	0.04	0.82	0.82	XXX
93925	TC	A	Lower extremity study	0.00	6.60	NA	0.35	6.95	NA	XXX
93925	.....	A	Lower extremity study	0.58	6.80	NA	0.39	7.77	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
93926	26	A	Lower extremity study	0.39	0.13	0.13	0.04	0.56	0.56	XXX
93926	TC	A	Lower extremity study	0.00	3.93	NA	0.23	4.16	NA	XXX
93926		A	Lower extremity study	0.39	4.06	NA	0.27	4.72	NA	XXX
93930	26	A	Upper extremity study	0.46	0.16	0.16	0.04	0.66	0.66	XXX
93930	TC	A	Upper extremity study	0.00	5.21	NA	0.37	5.58	NA	XXX
93930		A	Upper extremity study	0.46	5.37	NA	0.41	6.24	NA	XXX
93931	26	A	Upper extremity study	0.31	0.10	0.10	0.03	0.44	0.44	XXX
93931	TC	A	Upper extremity study	0.00	3.39	NA	0.24	3.63	NA	XXX
93931		A	Upper extremity study	0.31	3.49	NA	0.27	4.07	NA	XXX
93965	26	A	Extremity study	0.35	0.12	0.12	0.02	0.49	0.49	XXX
93965	TC	A	Extremity study	0.00	2.68	NA	0.12	2.80	NA	XXX
93965		A	Extremity study	0.35	2.80	NA	0.14	3.29	NA	XXX
93970	26	A	Extremity study	0.68	0.23	0.23	0.06	0.97	0.97	XXX
93970	TC	A	Extremity study	0.00	5.03	NA	0.40	5.43	NA	XXX
93970		A	Extremity study	0.68	5.26	NA	0.46	6.40	NA	XXX
93971	26	A	Extremity study	0.45	0.15	0.15	0.03	0.63	0.63	XXX
93971	TC	A	Extremity study	0.00	3.45	NA	0.27	3.72	NA	XXX
93971		A	Extremity study	0.45	3.60	NA	0.30	4.35	NA	XXX
93975	26	A	Vascular study	1.80	0.60	0.60	0.13	2.53	2.53	XXX
93975	TC	A	Vascular study	0.00	7.05	NA	0.43	7.48	NA	XXX
93975		A	Vascular study	1.80	7.65	NA	0.56	10.01	NA	XXX
93976	26	A	Vascular study	1.21	0.40	0.40	0.05	1.66	1.66	XXX
93976	TC	A	Vascular study	0.00	3.94	NA	0.30	4.24	NA	XXX
93976		A	Vascular study	1.21	4.34	NA	0.35	5.90	NA	XXX
93978	26	A	Vascular study	0.65	0.22	0.22	0.06	0.93	0.93	XXX
93978	TC	A	Vascular study	0.00	4.30	NA	0.37	4.67	NA	XXX
93978		A	Vascular study	0.65	4.52	NA	0.43	5.60	NA	XXX
93979	26	A	Vascular study	0.44	0.15	0.15	0.03	0.62	0.62	XXX
93979	TC	A	Vascular study	0.00	3.07	NA	0.24	3.31	NA	XXX
93979		A	Vascular study	0.44	3.22	NA	0.27	3.93	NA	XXX
93980	26	A	Penile vascular study	1.25	0.41	0.41	0.08	1.74	1.74	XXX
93980	TC	A	Penile vascular study	0.00	2.45	NA	0.34	2.79	NA	XXX
93980		A	Penile vascular study	1.25	2.86	NA	0.42	4.53	NA	XXX
93981	26	A	Penile vascular study	0.44	0.14	0.14	0.02	0.60	0.60	XXX
93981	TC	A	Penile vascular study	0.00	2.74	NA	0.31	3.05	NA	XXX
93981		A	Penile vascular study	0.44	2.88	NA	0.33	3.65	NA	XXX
93990	26	A	Doppler flow testing	0.25	0.09	0.09	0.03	0.37	0.37	XXX
93990	TC	A	Doppler flow testing	0.00	3.91	NA	0.23	4.14	NA	XXX
93990		A	Doppler flow testing	0.25	4.00	NA	0.26	4.51	NA	XXX
94010	26	A	Breathing capacity test	0.17	0.05	0.05	0.01	0.23	0.23	XXX
94010	TC	A	Breathing capacity test	0.00	0.62	NA	0.02	0.64	NA	XXX
94010		A	Breathing capacity test	0.17	0.67	NA	0.03	0.87	NA	XXX
94014		A	Patient recorded spirometry	0.52	0.76	NA	0.03	1.31	NA	XXX
94015		A	Patient recorded spirometry	0.00	0.59	NA	0.01	0.60	NA	XXX
94016		A	Review patient spirometry	0.52	0.17	0.17	0.02	0.71	0.71	XXX
94060	26	A	Evaluation of wheezing	0.31	0.09	0.09	0.01	0.41	0.41	XXX
94060	TC	A	Evaluation of wheezing	0.00	0.98	NA	0.06	1.04	NA	XXX
94060		A	Evaluation of wheezing	0.31	1.07	NA	0.07	1.45	NA	XXX
94070	26	A	Evaluation of wheezing	0.60	0.18	0.18	0.03	0.81	0.81	XXX
94070	TC	A	Evaluation of wheezing	0.00	0.64	NA	0.10	0.74	NA	XXX
94070		A	Evaluation of wheezing	0.60	0.82	NA	0.13	1.55	NA	XXX
94150	26	B	Vital capacity test	+0.07	0.03	0.03	0.01	0.11	0.11	XXX
94150	TC	B	Vital capacity test	+0.00	0.44	NA	0.01	0.45	NA	XXX
94150		B	Vital capacity test	+0.07	0.47	NA	0.02	0.56	NA	XXX
94200	26	A	Lung function test (MBC/MVV)	0.11	0.03	0.03	0.01	0.15	0.15	XXX
94200	TC	A	Lung function test (MBC/MVV)	0.00	0.41	NA	0.02	0.43	NA	XXX
94200		A	Lung function test (MBC/MVV)	0.11	0.44	NA	0.03	0.58	NA	XXX
94240	26	A	Residual lung capacity	0.26	0.08	0.08	0.01	0.35	0.35	XXX
94240	TC	A	Residual lung capacity	0.00	0.58	NA	0.05	0.63	NA	XXX
94240		A	Residual lung capacity	0.26	0.66	NA	0.06	0.98	NA	XXX
94250	26	A	Expired gas collection	0.11	0.03	0.03	0.01	0.15	0.15	XXX
94250	TC	A	Expired gas collection	0.00	0.61	NA	0.01	0.62	NA	XXX
94250		A	Expired gas collection	0.11	0.64	NA	0.02	0.77	NA	XXX
94260	26	A	Thoracic gas volume	0.13	0.04	0.04	0.01	0.18	0.18	XXX
94260	TC	A	Thoracic gas volume	0.00	0.54	NA	0.04	0.58	NA	XXX
94260		A	Thoracic gas volume	0.13	0.58	NA	0.05	0.76	NA	XXX
94350	26	A	Lung nitrogen washout curve	0.26	0.08	0.08	0.01	0.35	0.35	XXX
94350	TC	A	Lung nitrogen washout curve	0.00	0.68	NA	0.04	0.72	NA	XXX
94350		A	Lung nitrogen washout curve	0.26	0.76	NA	0.05	1.07	NA	XXX
94360	26	A	Measure airflow resistance	0.26	0.08	0.08	0.01	0.35	0.35	XXX
94360	TC	A	Measure airflow resistance	0.00	0.62	NA	0.06	0.68	NA	XXX
94360		A	Measure airflow resistance	0.26	0.70	NA	0.07	1.03	NA	XXX
94370	26	A	Breath airway closing volume	0.26	0.08	0.08	0.01	0.35	0.35	XXX
94370	TC	A	Breath airway closing volume	0.00	0.64	NA	0.02	0.66	NA	XXX
94370		A	Breath airway closing volume	0.26	0.72	NA	0.03	1.01	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
94375	26	A	Respiratory flow volume loop	0.31	0.09	0.09	0.01	0.41	0.41	XXX
94375	TC	A	Respiratory flow volume loop	0.00	0.51	NA	0.02	0.53	NA	XXX
94375		A	Respiratory flow volume loop	0.31	0.60	NA	0.03	0.94	NA	XXX
94400	26	A	CO2 breathing response curve	0.40	0.12	0.12	0.03	0.55	0.55	XXX
94400	TC	A	CO2 breathing response curve	0.00	0.72	NA	0.06	0.78	NA	XXX
94400		A	CO2 breathing response curve	0.40	0.84	NA	0.09	1.33	NA	XXX
94450	26	A	Hypoxia response curve	0.40	0.12	0.12	0.02	0.54	0.54	XXX
94450	TC	A	Hypoxia response curve	0.00	0.73	NA	0.02	0.75	NA	XXX
94450		A	Hypoxia response curve	0.40	0.85	NA	0.04	1.29	NA	XXX
94452	26	A	Hast w/report	0.31	0.09	0.09	0.02	0.42	0.42	XXX
94452	TC	A	Hast w/report	0.00	0.93	NA	0.02	0.95	NA	XXX
94452		A	Hast w/report	0.31	1.02	NA	0.04	1.37	NA	XXX
94453	26	A	Hast w/oxygen titrate	0.40	0.12	0.12	0.02	0.54	0.54	XXX
94453	TC	A	Hast w/oxygen titrate	0.00	1.39	NA	0.02	1.41	NA	XXX
94453		A	Hast w/oxygen titrate	0.40	1.51	NA	0.04	1.95	NA	XXX
94620	26	A	Pulmonary stress test/simple	0.64	0.20	0.20	0.03	0.87	0.87	XXX
94620	TC	A	Pulmonary stress test/simple	0.00	2.30	NA	0.10	2.40	NA	XXX
94620		A	Pulmonary stress test/simple	0.64	2.50	NA	0.13	3.27	NA	XXX
94621	26	A	Pulm stress test/complex	1.42	0.44	0.44	0.06	1.92	1.92	XXX
94621	TC	A	Pulm stress test/complex	0.00	1.77	NA	0.10	1.87	NA	XXX
94621		A	Pulm stress test/complex	1.42	2.21	NA	0.16	3.79	NA	XXX
94640		A	Airway inhalation treatment	0.00	0.30	NA	0.02	0.32	NA	XXX
94642		C	Aerosol inhalation treatment	0.00	0.00	0.00	0.00	0.00	0.00	XXX
94656		A	Initial ventilator mgmt	1.22	1.16	0.32	0.06	2.44	1.60	XXX
94657		A	Continued ventilator mgmt	0.83	0.98	0.25	0.04	1.85	1.12	XXX
94660		A	Pos airway pressure, CPAP	0.76	0.65	0.23	0.04	1.45	1.03	XXX
94662		A	Neg press ventilation, cnp	0.76	NA	0.23	0.03	NA	1.02	XXX
94664		A	Evaluate pt use of inhaler	0.00	0.31	NA	0.04	0.35	NA	XXX
94667		A	Chest wall manipulation	0.00	0.52	NA	0.05	0.57	NA	XXX
94668		A	Chest wall manipulation	0.00	0.45	NA	0.02	0.47	NA	XXX
94680	26	A	Exhaled air analysis, o2	0.26	0.08	0.08	0.01	0.35	0.35	XXX
94680	TC	A	Exhaled air analysis, o2	0.00	1.79	NA	0.06	1.85	NA	XXX
94680		A	Exhaled air analysis, o2	0.26	1.87	NA	0.07	2.20	NA	XXX
94681	26	A	Exhaled air analysis, o2/co2	0.20	0.06	0.06	0.01	0.27	0.27	XXX
94681	TC	A	Exhaled air analysis, o2/co2	0.00	2.47	NA	0.12	2.59	NA	XXX
94681		A	Exhaled air analysis, o2/co2	0.20	2.53	NA	0.13	2.86	NA	XXX
94690	26	A	Exhaled air analysis	0.07	0.02	0.02	0.01	0.10	0.10	XXX
94690	TC	A	Exhaled air analysis	0.00	1.98	NA	0.04	2.02	NA	XXX
94690		A	Exhaled air analysis	0.07	2.00	NA	0.05	2.12	NA	XXX
94720	26	A	Monoxide diffusing capacity	0.26	0.08	0.08	0.01	0.35	0.35	XXX
94720	TC	A	Monoxide diffusing capacity	0.00	0.92	NA	0.06	0.98	NA	XXX
94720		A	Monoxide diffusing capacity	0.26	1.00	NA	0.07	1.33	NA	XXX
94725	26	A	Membrane diffusion capacity	0.26	0.08	0.08	0.01	0.35	0.35	XXX
94725	TC	A	Membrane diffusion capacity	0.00	2.84	NA	0.12	2.96	NA	XXX
94725		A	Membrane diffusion capacity	0.26	2.92	NA	0.13	3.31	NA	XXX
94750	26	A	Pulmonary compliance study	0.23	0.07	0.07	0.01	0.31	0.31	XXX
94750	TC	A	Pulmonary compliance study	0.00	1.27	NA	0.04	1.31	NA	XXX
94750		A	Pulmonary compliance study	0.23	1.34	NA	0.05	1.62	NA	XXX
94760		T	Measure blood oxygen level	0.00	0.04	NA	0.02	0.06	NA	XXX
94761		T	Measure blood oxygen level	0.00	0.07	NA	0.06	0.13	NA	XXX
94762		A	Measure blood oxygen level	0.00	0.47	NA	0.10	0.57	NA	XXX
94770	26	A	Exhaled carbon dioxide test	0.15	0.04	0.04	0.01	0.20	0.20	XXX
94770	TC	A	Exhaled carbon dioxide test	0.00	0.71	NA	0.07	0.78	NA	XXX
94770		A	Exhaled carbon dioxide test	0.15	0.75	NA	0.08	0.98	NA	XXX
94772	26	C	Breath recording, infant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
94772	TC	C	Breath recording, infant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
94772		C	Breath recording, infant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
94799	26	C	Pulmonary service/procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
94799	TC	C	Pulmonary service/procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
94799		C	Pulmonary service/procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95004		A	Percut allergy skin tests	0.00	0.10	NA	0.01	0.11	NA	XXX
95010		A	Percut allergy titrate test	0.15	0.32	0.06	0.01	0.48	0.22	XXX
95015		A	Id allergy titrate-drug/bug	0.15	0.14	0.06	0.01	0.30	0.22	XXX
95024		A	Id allergy test, drug/bug	0.00	0.15	NA	0.01	0.16	NA	XXX
95027		A	Id allergy titrate-airborne	0.00	0.15	NA	0.01	0.16	NA	XXX
95028		A	Id allergy test-delayed type	0.00	0.23	NA	0.01	0.24	NA	XXX
95044		A	Allergy patch tests	0.00	0.20	NA	0.01	0.21	NA	XXX
95052		A	Photo patch test	0.00	0.25	NA	0.01	0.26	NA	XXX
95056		A	Photosensitivity tests	0.00	0.17	NA	0.01	0.18	NA	XXX
95060		A	Eye allergy tests	0.00	0.35	NA	0.02	0.37	NA	XXX
95065		A	Nose allergy test	0.00	0.20	NA	0.01	0.21	NA	XXX
95070		A	Bronchial allergy tests	0.00	2.29	NA	0.02	2.31	NA	XXX
95071		A	Bronchial allergy tests	0.00	2.93	NA	0.02	2.95	NA	XXX
95075		A	Ingestion challenge test	0.95	0.82	0.38	0.03	1.80	1.36	XXX
95078		A	Provocative testing	0.00	0.25	NA	0.02	0.27	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
95115	.....	A	Immunotherapy, one injection	0.00	0.39	NA	0.02	0.41	NA	XXX
95117	.....	A	Immunotherapy injections	0.00	0.50	NA	0.02	0.52	NA	XXX
95120	.....	I	Immunotherapy, one injection	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95125	.....	I	Immunotherapy, many antigens	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95130	.....	I	Immunotherapy, insect venom	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95131	.....	I	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95132	.....	I	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95133	.....	I	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95134	.....	I	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95144	.....	A	Antigen therapy services	0.06	0.19	0.02	0.01	0.26	0.09	XXX
95145	.....	A	Antigen therapy services	0.06	0.32	0.02	0.01	0.39	0.09	XXX
95146	.....	A	Antigen therapy services	0.06	0.44	0.03	0.01	0.51	0.10	XXX
95147	.....	A	Antigen therapy services	0.06	0.42	0.02	0.01	0.49	0.09	XXX
95148	.....	A	Antigen therapy services	0.06	0.58	0.03	0.01	0.65	0.10	XXX
95149	.....	A	Antigen therapy services	0.06	0.80	0.03	0.01	0.87	0.10	XXX
95165	.....	A	Antigen therapy services	0.06	0.19	0.02	0.01	0.26	0.09	XXX
95170	.....	A	Antigen therapy services	0.06	0.13	0.03	0.01	0.20	0.10	XXX
95180	.....	A	Rapid desensitization	2.01	2.04	0.93	0.04	4.09	2.98	XXX
95199	.....	C	Allergy immunology services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95250	.....	A	Glucose monitoring, cont	0.00	4.11	NA	0.01	4.12	NA	XXX
95251	.....	A	Gluc monitor, cont, phys i&r	0.52	0.19	0.19	0.02	0.73	0.73	XXX
95805	26	A	Multiple sleep latency test	1.88	0.66	0.66	0.09	2.63	2.63	XXX
95805	TC	A	Multiple sleep latency test	0.00	16.65	NA	0.34	16.99	NA	XXX
95805	.....	A	Multiple sleep latency test	1.88	17.31	NA	0.43	19.62	NA	XXX
95806	26	A	Sleep study, unattended	1.66	0.54	0.54	0.08	2.28	2.28	XXX
95806	TC	A	Sleep study, unattended	0.00	2.80	NA	0.31	3.11	NA	XXX
95806	.....	A	Sleep study, unattended	1.66	3.34	NA	0.39	5.39	NA	XXX
95807	26	A	Sleep study, attended	1.66	0.53	0.53	0.08	2.27	2.27	XXX
95807	TC	A	Sleep study, attended	0.00	11.35	NA	0.42	11.77	NA	XXX
95807	.....	A	Sleep study, attended	1.66	11.88	NA	0.50	14.04	NA	XXX
95808	26	A	Polysomnography, 1-3	2.65	0.92	0.92	0.13	3.70	3.70	XXX
95808	TC	A	Polysomnography, 1-3	0.00	12.31	NA	0.42	12.73	NA	XXX
95808	.....	A	Polysomnography, 1-3	2.65	13.23	NA	0.55	16.43	NA	XXX
95810	26	A	Polysomnography, 4 or more	3.52	1.18	1.18	0.17	4.87	4.87	XXX
95810	TC	A	Polysomnography, 4 or more	0.00	16.36	NA	0.42	16.78	NA	XXX
95810	.....	A	Polysomnography, 4 or more	3.52	17.54	NA	0.59	21.65	NA	XXX
95811	26	A	Polysomnography w/cpap	3.79	1.27	1.27	0.18	5.24	5.24	XXX
95811	TC	A	Polysomnography w/cpap	0.00	17.97	NA	0.43	18.40	NA	XXX
95811	.....	A	Polysomnography w/cpap	3.79	19.24	NA	0.61	23.64	NA	XXX
95812	26	A	Eeg, 41-60 minutes	1.08	0.45	0.45	0.06	1.59	1.59	XXX
95812	TC	A	Eeg, 41-60 minutes	0.00	3.59	NA	0.11	3.70	NA	XXX
95812	.....	A	Eeg, 41-60 minutes	1.08	4.04	NA	0.17	5.29	NA	XXX
95813	26	A	Eeg, over 1 hour	1.73	0.70	0.70	0.09	2.52	2.52	XXX
95813	TC	A	Eeg, over 1 hour	0.00	4.33	NA	0.11	4.44	NA	XXX
95813	.....	A	Eeg, over 1 hour	1.73	5.03	NA	0.20	6.96	NA	XXX
95816	26	A	Eeg, awake and drowsy	1.08	0.46	0.46	0.06	1.60	1.60	XXX
95816	TC	A	Eeg, awake and drowsy	0.00	3.26	NA	0.10	3.36	NA	XXX
95816	.....	A	Eeg, awake and drowsy	1.08	3.72	NA	0.16	4.96	NA	XXX
95819	26	A	Eeg, awake and asleep	1.08	0.46	0.46	0.06	1.60	1.60	XXX
95819	TC	A	Eeg, awake and asleep	0.00	2.53	NA	0.10	2.63	NA	XXX
95819	.....	A	Eeg, awake and asleep	1.08	2.99	NA	0.16	4.23	NA	XXX
95822	26	A	Eeg, coma or sleep only	1.08	0.46	0.46	0.06	1.60	1.60	XXX
95822	TC	A	Eeg, coma or sleep only	0.00	4.15	NA	0.13	4.28	NA	XXX
95822	.....	A	Eeg, coma or sleep only	1.08	4.61	NA	0.19	5.88	NA	XXX
95824	26	A	Eeg, cerebral death only	0.74	0.31	0.31	0.04	1.09	1.09	XXX
95824	TC	C	Eeg, cerebral death only	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95824	.....	C	Eeg, cerebral death only	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95827	26	A	Eeg, all night recording	1.08	0.41	0.41	0.05	1.54	1.54	XXX
95827	TC	A	Eeg, all night recording	0.00	2.30	NA	0.14	2.44	NA	XXX
95827	.....	A	Eeg, all night recording	1.08	2.71	NA	0.19	3.98	NA	XXX
95829	26	A	Surgery electrocorticogram	6.20	2.32	2.32	0.48	9.00	9.00	XXX
95829	TC	A	Surgery electrocorticogram	0.00	28.77	NA	0.02	28.79	NA	XXX
95829	.....	A	Surgery electrocorticogram	6.20	31.09	NA	0.50	37.79	NA	XXX
95830	.....	A	Insert electrodes for EEG	1.70	3.30	0.73	0.11	5.11	2.54	XXX
95831	.....	A	Limb muscle testing, manual	0.28	0.46	0.13	0.01	0.75	0.42	XXX
95832	.....	A	Hand muscle testing, manual	0.29	0.33	0.12	0.02	0.64	0.43	XXX
95833	.....	A	Body muscle testing, manual	0.47	0.58	0.23	0.02	1.07	0.72	XXX
95834	.....	A	Body muscle testing, manual	0.60	0.63	0.28	0.03	1.26	0.91	XXX
95851	.....	A	Range of motion measurements	0.16	0.36	0.08	0.01	0.53	0.25	XXX
95852	.....	A	Range of motion measurements	0.11	0.26	0.05	0.01	0.38	0.17	XXX
95857	.....	A	Tensilon test	0.53	0.60	0.23	0.02	1.15	0.78	XXX
95860	26	A	Muscle test, one limb	0.96	0.42	0.42	0.05	1.43	1.43	XXX
95860	TC	A	Muscle test, one limb	0.00	1.00	NA	0.02	1.02	NA	XXX
95860	.....	A	Muscle test, one limb	0.96	1.42	NA	0.07	2.45	NA	XXX
95861	26	A	Muscle test, 2 limbs	1.54	0.68	0.68	0.07	2.29	2.29	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
95861	TC	A	Muscle test, 2 limbs	0.00	0.73	NA	0.06	0.79	NA	XXX
95861	.....	A	Muscle test, 2 limbs	1.54	1.41	NA	0.13	3.08	NA	XXX
95863	26	A	Muscle test, 3 limbs	1.87	0.80	0.80	0.09	2.76	2.76	XXX
95863	TC	A	Muscle test, 3 limbs	0.00	0.94	NA	0.06	1.00	NA	XXX
95863	.....	A	Muscle test, 3 limbs	1.87	1.74	NA	0.15	3.76	NA	XXX
95864	26	A	Muscle test, 4 limbs	1.99	0.87	0.87	0.09	2.95	2.95	XXX
95864	TC	A	Muscle test, 4 limbs	0.00	1.79	NA	0.12	1.91	NA	XXX
95864	.....	A	Muscle test, 4 limbs	1.99	2.66	NA	0.21	4.86	NA	XXX
95865	26	A	Muscle test, larynx	1.57	0.77	0.77	0.08	2.42	2.42	XXX
95865	TC	A	Muscle test, larynx	0.00	0.68	NA	0.03	0.71	NA	XXX
95865	.....	A	Muscle test, larynx	1.57	1.45	NA	0.11	3.13	NA	XXX
95866	26	A	Muscle test, hemidiaphragm	1.25	0.56	0.56	0.07	1.88	1.88	XXX
95866	TC	A	Muscle test, hemidiaphragm	0.00	0.20	NA	0.03	0.23	NA	XXX
95866	.....	A	Muscle test, hemidiaphragm	1.25	0.76	NA	0.10	2.11	NA	XXX
95867	26	A	Muscle test cran nerv unilat	0.79	0.35	0.35	0.03	1.17	1.17	XXX
95867	TC	A	Muscle test cran nerv unilat	0.00	0.58	NA	0.04	0.62	NA	XXX
95867	.....	A	Muscle test cran nerv unilat	0.79	0.93	NA	0.07	1.79	NA	XXX
95868	26	A	Muscle test cran nerve bilat	1.18	0.51	0.51	0.05	1.74	1.74	XXX
95868	TC	A	Muscle test cran nerve bilat	0.00	0.70	NA	0.05	0.75	NA	XXX
95868	.....	A	Muscle test cran nerve bilat	1.18	1.21	NA	0.10	2.49	NA	XXX
95869	26	A	Muscle test, thor paraspinal	0.37	0.16	0.16	0.02	0.55	0.55	XXX
95869	TC	A	Muscle test, thor paraspinal	0.00	0.21	NA	0.02	0.23	NA	XXX
95869	.....	A	Muscle test, thor paraspinal	0.37	0.37	NA	0.04	0.78	NA	XXX
95870	26	A	Muscle test, nonparaspinal	0.37	0.16	0.16	0.02	0.55	0.55	XXX
95870	TC	A	Muscle test, nonparaspinal	0.00	0.21	NA	0.02	0.23	NA	XXX
95870	.....	A	Muscle test, nonparaspinal	0.37	0.37	NA	0.04	0.78	NA	XXX
95872	26	A	Muscle test, one fiber	1.50	0.63	0.63	0.08	2.21	2.21	XXX
95872	TC	A	Muscle test, one fiber	0.00	0.60	NA	0.05	0.65	NA	XXX
95872	.....	A	Muscle test, one fiber	1.50	1.23	NA	0.13	2.86	NA	XXX
95873	26	A	Guide nerv destr, elec stim	0.37	0.16	0.16	0.02	0.55	0.55	ZZZ
95873	TC	A	Guide nerv destr, elec stim	0.00	0.20	NA	0.02	0.22	NA	ZZZ
95873	.....	A	Guide nerv destr, elec stim	0.37	0.36	NA	0.04	0.77	NA	ZZZ
95874	26	A	Guide nerv destr, needle emg	0.37	0.17	0.17	0.02	0.56	0.56	ZZZ
95874	TC	A	Guide nerv destr, needle emg	0.00	0.20	NA	0.02	0.22	NA	ZZZ
95874	.....	A	Guide nerv destr, needle emg	0.37	0.37	NA	0.04	0.78	NA	ZZZ
95875	26	A	Limb exercise test	1.10	0.47	0.47	0.05	1.62	1.62	XXX
95875	TC	A	Limb exercise test	0.00	0.98	NA	0.06	1.04	NA	XXX
95875	.....	A	Limb exercise test	1.10	1.45	NA	0.11	2.66	NA	XXX
95900	26	A	Motor nerve conduction test	0.42	0.18	0.18	0.02	0.62	0.62	XXX
95900	TC	A	Motor nerve conduction test	0.00	1.08	NA	0.02	1.10	NA	XXX
95900	.....	A	Motor nerve conduction test	0.42	1.26	NA	0.04	1.72	NA	XXX
95903	26	A	Motor nerve conduction test	0.60	0.26	0.26	0.03	0.89	0.89	XXX
95903	TC	A	Motor nerve conduction test	0.00	0.93	NA	0.02	0.95	NA	XXX
95903	.....	A	Motor nerve conduction test	0.60	1.19	NA	0.05	1.84	NA	XXX
95904	26	A	Sense nerve conduction test	0.34	0.15	0.15	0.02	0.51	0.51	XXX
95904	TC	A	Sense nerve conduction test	0.00	0.94	NA	0.02	0.96	NA	XXX
95904	.....	A	Sense nerve conduction test	0.34	1.09	NA	0.04	1.47	NA	XXX
95920	26	A	Intraop nerve test add-on	2.11	0.93	0.93	0.16	3.20	3.20	ZZZ
95920	TC	A	Intraop nerve test add-on	0.00	1.31	NA	0.07	1.38	NA	ZZZ
95920	.....	A	Intraop nerve test add-on	2.11	2.24	NA	0.23	4.58	NA	ZZZ
95921	26	A	Autonomic nerv function test	0.90	0.33	0.33	0.04	1.27	1.27	XXX
95921	TC	A	Autonomic nerv function test	0.00	0.38	NA	0.02	0.40	NA	XXX
95921	.....	A	Autonomic nerv function test	0.90	0.71	NA	0.06	1.67	NA	XXX
95922	26	A	Autonomic nerv function test	0.96	0.40	0.40	0.05	1.41	1.41	XXX
95922	TC	A	Autonomic nerv function test	0.00	0.38	NA	0.02	0.40	NA	XXX
95922	.....	A	Autonomic nerv function test	0.96	0.78	NA	0.07	1.81	NA	XXX
95923	26	A	Autonomic nerv function test	0.90	0.38	0.38	0.05	1.33	1.33	XXX
95923	TC	A	Autonomic nerv function test	0.00	1.56	NA	0.02	1.58	NA	XXX
95923	.....	A	Autonomic nerv function test	0.90	1.94	NA	0.07	2.91	NA	XXX
95925	26	A	Somatosensory testing	0.54	0.22	0.22	0.04	0.80	0.80	XXX
95925	TC	A	Somatosensory testing	0.00	0.91	NA	0.06	0.97	NA	XXX
95925	.....	A	Somatosensory testing	0.54	1.13	NA	0.10	1.77	NA	XXX
95926	26	A	Somatosensory testing	0.54	0.23	0.23	0.03	0.80	0.80	XXX
95926	TC	A	Somatosensory testing	0.00	0.91	NA	0.06	0.97	NA	XXX
95926	.....	A	Somatosensory testing	0.54	1.14	NA	0.09	1.77	NA	XXX
95927	26	A	Somatosensory testing	0.54	0.25	0.25	0.04	0.83	0.83	XXX
95927	TC	A	Somatosensory testing	0.00	0.91	NA	0.06	0.97	NA	XXX
95927	.....	A	Somatosensory testing	0.54	1.16	NA	0.10	1.80	NA	XXX
95928	26	A	C motor evoked, uppr limbs	1.50	0.65	0.65	0.06	2.21	2.21	XXX
95928	TC	A	C motor evoked, uppr limbs	0.00	2.38	NA	0.03	2.41	NA	XXX
95928	.....	A	C motor evoked, uppr limbs	1.50	3.03	NA	0.09	4.62	NA	XXX
95929	26	A	C motor evoked, lwr limbs	1.50	0.65	0.65	0.06	2.21	2.21	XXX
95929	TC	A	C motor evoked, lwr limbs	0.00	2.57	NA	0.03	2.60	NA	XXX
95929	.....	A	C motor evoked, lwr limbs	1.50	3.22	NA	0.09	4.81	NA	XXX
95930	26	A	Visual evoked potential test	0.35	0.15	0.15	0.02	0.52	0.52	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
95930	TC	A	Visual evoked potential test	0.00	2.10	NA	0.01	2.11	NA	XXX
95930	.....	A	Visual evoked potential test	0.35	2.25	NA	0.03	2.63	NA	XXX
95933	26	A	Blink reflex test	0.59	0.24	0.24	0.04	0.87	0.87	XXX
95933	TC	A	Blink reflex test	0.00	0.78	NA	0.06	0.84	NA	XXX
95933	.....	A	Blink reflex test	0.59	1.02	NA	0.10	1.71	NA	XXX
95934	26	A	H-reflex test	0.51	0.22	0.22	0.02	0.75	0.75	XXX
95934	TC	A	H-reflex test	0.00	0.21	NA	0.02	0.23	NA	XXX
95934	.....	A	H-reflex test	0.51	0.43	NA	0.04	0.98	NA	XXX
95936	26	A	H-reflex test	0.55	0.24	0.24	0.03	0.82	0.82	XXX
95936	TC	A	H-reflex test	0.00	0.21	NA	0.02	0.23	NA	XXX
95936	.....	A	H-reflex test	0.55	0.45	NA	0.05	1.05	NA	XXX
95937	26	A	Neuromuscular junction test	0.65	0.27	0.27	0.08	1.00	1.00	XXX
95937	TC	A	Neuromuscular junction test	0.00	0.34	NA	0.02	0.36	NA	XXX
95937	.....	A	Neuromuscular junction test	0.65	0.61	NA	0.10	1.36	NA	XXX
95950	26	A	Ambulatory eeg monitoring	1.51	0.64	0.64	0.08	2.23	2.23	XXX
95950	TC	A	Ambulatory eeg monitoring	0.00	3.30	NA	0.43	3.73	NA	XXX
95950	.....	A	Ambulatory eeg monitoring	1.51	3.94	NA	0.51	5.96	NA	XXX
95951	26	A	EEG monitoring/videorecord	5.99	2.56	2.56	0.32	8.87	8.87	XXX
95951	TC	C	EEG monitoring/videorecord	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95951	.....	C	EEG monitoring/videorecord	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95953	26	A	EEG monitoring/computer	3.08	1.29	1.29	0.17	4.54	4.54	XXX
95953	TC	A	EEG monitoring/computer	0.00	6.35	NA	0.43	6.78	NA	XXX
95953	.....	A	EEG monitoring/computer	3.08	7.64	NA	0.60	11.32	NA	XXX
95954	26	A	EEG monitoring/giving drugs	2.45	1.04	1.04	0.13	3.62	3.62	XXX
95954	TC	A	EEG monitoring/giving drugs	0.00	3.19	NA	0.06	3.25	NA	XXX
95954	.....	A	EEG monitoring/giving drugs	2.45	4.23	NA	0.19	6.87	NA	XXX
95955	26	A	EEG during surgery	1.01	0.36	0.36	0.05	1.42	1.42	XXX
95955	TC	A	EEG during surgery	0.00	1.97	NA	0.17	2.14	NA	XXX
95955	.....	A	EEG during surgery	1.01	2.33	NA	0.22	3.56	NA	XXX
95956	26	A	Eeg monitoring, cable/radio	3.08	1.30	1.30	0.16	4.54	4.54	XXX
95956	TC	A	Eeg monitoring, cable/radio	0.00	14.15	NA	0.43	14.58	NA	XXX
95956	.....	A	Eeg monitoring, cable/radio	3.08	15.45	NA	0.59	19.12	NA	XXX
95957	26	A	EEG digital analysis	1.98	0.85	0.85	0.11	2.94	2.94	XXX
95957	TC	A	EEG digital analysis	0.00	1.70	NA	0.12	1.82	NA	XXX
95957	.....	A	EEG digital analysis	1.98	2.55	NA	0.23	4.76	NA	XXX
95958	26	A	EEG monitoring/function test	4.24	1.75	1.75	0.21	6.20	6.20	XXX
95958	TC	A	EEG monitoring/function test	0.00	1.75	NA	0.13	1.88	NA	XXX
95958	.....	A	EEG monitoring/function test	4.24	3.50	NA	0.34	8.08	NA	XXX
95961	26	A	Electrode stimulation, brain	2.97	1.32	1.32	0.48	4.77	4.77	XXX
95961	TC	A	Electrode stimulation, brain	0.00	1.31	NA	0.07	1.38	NA	XXX
95961	.....	A	Electrode stimulation, brain	2.97	2.63	NA	0.55	6.15	NA	XXX
95962	26	A	Electrode stim, brain add-on	3.21	1.39	1.39	0.32	4.92	4.92	ZZZ
95962	TC	A	Electrode stim, brain add-on	0.00	1.31	NA	0.07	1.38	NA	ZZZ
95962	.....	A	Electrode stim, brain add-on	3.21	2.70	NA	0.39	6.30	NA	ZZZ
95965	26	A	Meg, spontaneous	7.99	3.43	3.43	0.46	11.88	11.88	XXX
95965	TC	C	Meg, spontaneous	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95965	.....	C	Meg, spontaneous	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95966	26	A	Meg, evoked, single	3.99	1.71	1.71	0.19	5.89	5.89	XXX
95966	TC	C	Meg, evoked, single	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95966	.....	C	Meg, evoked, single	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95967	26	A	Meg, evoked, each add'l	3.49	1.18	1.18	0.16	4.83	4.83	ZZZ
95967	TC	C	Meg, evoked, each add'l	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
95967	.....	C	Meg, evoked, each add'l	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
95970	.....	A	Analyze neurostim, no prog	0.45	0.85	0.14	0.03	1.33	0.62	XXX
95971	.....	A	Analyze neurostim, simple	0.78	0.68	0.22	0.07	1.53	1.07	XXX
95972	.....	A	Analyze neurostim, complex	1.50	1.21	0.49	0.14	2.85	2.13	XXX
95973	.....	A	Analyze neurostim, complex	0.92	0.62	0.34	0.07	1.61	1.33	ZZZ
95974	.....	A	Cranial neurostim, complex	3.00	1.70	1.30	0.16	4.86	4.46	XXX
95975	.....	A	Cranial neurostim, complex	1.70	0.89	0.73	0.12	2.71	2.55	ZZZ
95978	.....	A	Analyze neurostim brain/1h	3.50	1.94	1.30	0.18	5.62	4.98	XXX
95979	.....	A	Analyz neurostim brain addon	1.64	0.87	0.69	0.08	2.59	2.41	ZZZ
95990	.....	A	Spin/brain pump refil & main	0.00	1.50	NA	0.06	1.56	NA	XXX
95991	.....	A	Spin/brain pump refil & main	0.77	1.46	0.17	0.06	2.29	1.00	XXX
95999	.....	C	Neurological procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
96000	.....	A	Motion analysis, video/3d	1.80	NA	0.53	0.11	NA	2.44	XXX
96001	.....	A	Motion test w/ft press meas	2.15	NA	0.66	0.10	NA	2.91	XXX
96002	.....	A	Dynamic surface emg	0.41	NA	0.15	0.02	NA	0.58	XXX
96003	.....	A	Dynamic fine wire emg	0.37	NA	0.12	0.02	NA	0.51	XXX
96004	.....	A	Phys review of motion tests	2.14	0.94	0.94	0.11	3.19	3.19	XXX
96101	.....	A	Psycho testing by psych/phys	1.86	0.65	0.63	0.05	2.56	2.54	XXX
96102	.....	A	Psycho testing by technician	0.50	0.66	0.17	0.01	1.17	0.68	XXX
96103	.....	A	Psycho testing admin by comp	0.51	0.21	0.17	0.02	0.74	0.70	XXX
96105	.....	A	Assessment of aphasia	0.00	1.77	NA	0.18	1.95	NA	XXX
96110	.....	A	Developmental test, lim	0.00	0.18	NA	0.18	0.36	NA	XXX
96111	.....	A	Developmental test, extend	2.60	1.05	NA	0.18	3.83	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
96116	.....	A	Neurobehavioral status exam	1.86	0.83	0.64	0.18	2.87	2.68	XXX
96118	.....	A	Neuropsych tst by psych/phys	1.86	1.39	0.63	0.18	3.43	2.67	XXX
96119	.....	A	Neuropsych testing by tech	0.55	1.02	0.19	0.18	1.75	0.92	XXX
96120	.....	A	Neuropsych tst admin w/comp	0.51	0.74	0.17	0.02	1.27	0.70	XXX
96150	.....	A	Assess hlth/behave, init	0.50	0.18	0.18	0.01	0.69	0.69	XXX
96151	.....	A	Assess hlth/behave, subseq	0.48	0.18	0.17	0.01	0.67	0.66	XXX
96152	.....	A	Intervene hlth/behave, indiv	0.46	0.17	0.16	0.01	0.64	0.63	XXX
96153	.....	A	Intervene hlth/behave, group	0.10	0.04	0.03	0.01	0.15	0.14	XXX
96154	.....	A	Interv hlth/behav, fam w/pt	0.45	0.17	0.16	0.01	0.63	0.62	XXX
96155	.....	N	Interv hlth/behav fam no pt	+0.44	0.18	0.17	0.02	0.64	0.63	XXX
96401	.....	A	Chemo, anti-neopl, sq/im	0.21	1.53	1.53	0.01	1.75	1.75	XXX
96402	.....	A	Chemo hormon antineopl sq/im	0.19	0.74	0.74	0.01	0.94	0.94	XXX
96405	.....	A	Chemo intralesional, up to 7	0.52	2.78	0.24	0.03	3.33	0.79	000
96406	.....	A	Chemo intralesional over 7	0.80	3.08	0.29	0.03	3.91	1.12	000
96409	.....	A	Chemo, iv push, sngl drug	0.24	2.93	2.93	0.06	3.23	3.23	XXX
96411	.....	A	Chemo, iv push, addl drug	0.20	1.61	1.61	0.06	1.87	1.87	ZZZ
96413	.....	A	Chemo, iv infusion, 1 hr	0.28	4.20	4.20	0.08	4.56	4.56	XXX
96415	.....	A	Chemo, iv infusion, addl hr	0.19	0.77	0.77	0.07	1.03	1.03	ZZZ
96416	.....	A	Chemo prolong infuse w/pump	0.21	4.61	4.61	0.08	4.90	4.90	XXX
96417	.....	A	Chemo iv infus each addl seq	0.21	1.95	1.95	0.07	2.23	2.23	ZZZ
96420	.....	A	Chemo, ia, push tecnique	0.17	2.66	NA	0.08	2.91	NA	XXX
96422	.....	A	Chemo ia infusion up to 1 hr	0.17	4.84	NA	0.08	5.09	NA	XXX
96423	.....	A	Chemo ia infuse each addl hr	0.17	1.89	NA	0.02	2.08	NA	ZZZ
96425	.....	A	Chemotherapy,infusion method	0.17	4.48	NA	0.08	4.73	NA	XXX
96440	.....	A	Chemotherapy, intracavitary	2.37	8.04	1.23	0.17	10.58	3.77	000
96445	.....	A	Chemotherapy, intracavitary	2.20	8.05	1.18	0.14	10.39	3.52	000
96450	.....	A	Chemotherapy, into CNS	1.53	6.96	1.29	0.09	8.58	2.91	000
96521	.....	A	Refill/maint, portable pump	0.21	3.77	3.77	0.06	4.04	4.04	XXX
96522	.....	A	Refill/maint pump/resvr syst	0.21	2.65	2.65	0.06	2.92	2.92	XXX
96523	.....	T	Irrig drug delivery device	0.04	0.69	0.69	0.01	0.74	0.74	XXX
96542	.....	A	Chemotherapy injection	0.75	4.24	0.66	0.07	5.06	1.48	XXX
96549	.....	C	Chemotherapy, unspecified	0.00	0.00	0.00	0.00	0.00	0.00	XXX
96567	.....	A	Photodynamic tx, skin	0.00	1.96	NA	0.04	2.00	NA	XXX
96570	.....	A	Photodynamic tx, 30 min	1.10	NA	0.37	0.11	NA	1.58	ZZZ
96571	.....	A	Photodynamic tx, addl 15 min	0.55	NA	0.19	0.03	NA	0.77	ZZZ
96900	.....	A	Ultraviolet light therapy	0.00	0.44	NA	0.02	0.46	NA	XXX
96902	.....	B	Trichogram	+0.41	0.18	0.16	0.01	0.60	0.58	XXX
96910	.....	A	Photochemotherapy with UV-B	0.00	0.99	NA	0.04	1.03	NA	XXX
96912	.....	A	Photochemotherapy with UV-A	0.00	1.26	NA	0.05	1.31	NA	XXX
96913	.....	A	Photochemotherapy, UV-A or B	0.00	1.68	NA	0.10	1.78	NA	XXX
96920	.....	A	Laser tx, skin < 250 sq cm	1.15	2.54	0.56	0.02	3.71	1.73	000
96921	.....	A	Laser tx, skin 250-500 sq cm	1.17	2.61	0.57	0.03	3.81	1.77	000
96922	.....	A	Laser tx, skin > 500 sq cm	2.10	3.49	0.62	0.04	5.63	2.76	000
96999	.....	C	Dermatological procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97001	.....	A	Pt evaluation	1.20	0.75	0.45	0.05	2.00	1.70	XXX
97002	.....	A	Pt re-evaluation	0.60	0.44	0.23	0.02	1.06	0.85	XXX
97003	.....	A	Ot evaluation	1.20	0.88	0.40	0.06	2.14	1.66	XXX
97004	.....	A	Ot re-evaluation	0.60	0.67	0.19	0.02	1.29	0.81	XXX
97005	.....	I	Athletic train eval	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97006	.....	I	Athletic train reeval	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97010	.....	B	Hot or cold packs therapy	+0.06	0.05	NA	0.01	0.12	NA	XXX
97012	.....	A	Mechanical traction therapy	0.25	0.13	NA	0.01	0.39	NA	XXX
97014	.....	I	Electric stimulation therapy	+0.18	0.19	0.19	0.01	0.38	0.38	XXX
97016	.....	A	Vasopneumatic device therapy	0.18	0.18	NA	0.01	0.37	NA	XXX
97018	.....	A	Paraffin bath therapy	0.06	0.10	NA	0.01	0.17	NA	XXX
97022	.....	A	Whirlpool therapy	0.17	0.21	NA	0.01	0.39	NA	XXX
97024	.....	A	Diathermy eg, microwave	0.06	0.07	NA	0.01	0.14	NA	XXX
97026	.....	A	Infrared therapy	0.06	0.06	NA	0.01	0.13	NA	XXX
97028	.....	A	Ultraviolet therapy	0.08	0.07	NA	0.01	0.16	NA	XXX
97032	.....	A	Electrical stimulation	0.25	0.16	NA	0.01	0.42	NA	XXX
97033	.....	A	Electric current therapy	0.26	0.27	NA	0.01	0.54	NA	XXX
97034	.....	A	Contrast bath therapy	0.21	0.15	NA	0.01	0.37	NA	XXX
97035	.....	A	Ultrasound therapy	0.21	0.10	NA	0.01	0.32	NA	XXX
97036	.....	A	Hydrotherapy	0.28	0.32	NA	0.01	0.61	NA	XXX
97039	.....	C	Physical therapy treatment	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97110	.....	A	Therapeutic exercises	0.45	0.27	NA	0.02	0.74	NA	XXX
97112	.....	A	Neuromuscular reeducation	0.45	0.31	NA	0.01	0.77	NA	XXX
97113	.....	A	Aquatic therapy/exercises	0.44	0.39	NA	0.01	0.84	NA	XXX
97116	.....	A	Gait training therapy	0.40	0.24	NA	0.01	0.65	NA	XXX
97124	.....	A	Massage therapy	0.35	0.23	NA	0.01	0.59	NA	XXX
97139	.....	C	Physical medicine procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97140	.....	A	Manual therapy	0.43	0.25	NA	0.01	0.69	NA	XXX
97150	.....	A	Group therapeutic procedures	0.27	0.18	NA	0.01	0.46	NA	XXX
97530	.....	A	Therapeutic activities	0.44	0.32	NA	0.01	0.77	NA	XXX
97532	.....	A	Cognitive skills development	0.44	0.20	NA	0.01	0.65	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
97533	.....	A	Sensory integration	0.44	0.24	NA	0.01	0.69	NA	XXX
97535	.....	A	Self care mngment training	0.45	0.33	NA	0.01	0.79	NA	XXX
97537	.....	A	Community/work reintegration	0.45	0.26	NA	0.01	0.72	NA	XXX
97542	.....	A	Wheelchair mngment training	0.45	0.28	NA	0.01	0.74	NA	XXX
97545	.....	R	Work hardening	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97546	.....	R	Work hardening add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
97597	.....	A	Active wound care/20 cm or <	0.58	0.66	NA	0.05	1.29	NA	XXX
97598	.....	A	Active wound care > 20 cm	0.80	0.79	NA	0.05	1.64	NA	XXX
97602	.....	B	Wound(s) care non-selective	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97605	.....	A	Neg press wound tx, < 50 cm	0.55	0.34	0.22	0.02	0.91	0.79	XXX
97606	.....	A	Neg press wound tx, > 50 cm	0.60	0.90	0.41	0.03	1.53	1.04	XXX
97750	.....	A	Physical performance test	0.45	0.32	NA	0.02	0.79	NA	XXX
97755	.....	A	Assistive technology assess	0.62	0.28	NA	0.02	0.92	NA	XXX
97760	.....	A	Orthotic mgmt and training	0.45	0.34	0.20	0.03	0.82	0.68	XXX
97761	.....	A	Prosthetic training	0.45	0.28	0.19	0.02	0.75	0.66	XXX
97762	.....	A	C/o for orthotic/prosth use	0.25	0.42	0.19	0.02	0.69	0.46	XXX
97799	.....	C	Physical medicine procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97802	.....	A	Medical nutrition, indiv, in	0.00	0.47	NA	0.01	0.48	NA	XXX
97803	.....	A	Med nutrition, indiv, subseq	0.00	0.47	NA	0.01	0.48	NA	XXX
97804	.....	A	Medical nutrition, group	0.00	0.18	NA	0.01	0.19	NA	XXX
97810	.....	N	Acupunct w/o stimul 15 min	+0.60	0.38	0.23	0.03	1.01	0.86	XXX
97811	.....	N	Acupunct w/o stimul addl 15m	+0.50	0.25	0.19	0.03	0.78	0.72	ZZZ
97813	.....	N	Acupunct w/stimul 15 min	+0.65	0.40	0.25	0.03	1.08	0.93	XXX
97814	.....	N	Acupunct w/stimul addl 15m	+0.55	0.30	0.21	0.03	0.88	0.79	ZZZ
98925	.....	A	Osteopathic manipulation	0.45	0.32	0.14	0.02	0.79	0.61	000
98926	.....	A	Osteopathic manipulation	0.65	0.41	0.25	0.03	1.09	0.93	000
98927	.....	A	Osteopathic manipulation	0.87	0.50	0.29	0.03	1.40	1.19	000
98928	.....	A	Osteopathic manipulation	1.03	0.59	0.34	0.04	1.66	1.41	000
98929	.....	A	Osteopathic manipulation	1.19	0.67	0.37	0.05	1.91	1.61	000
98940	.....	A	Chiropractic manipulation	0.45	0.23	0.12	0.01	0.69	0.58	000
98941	.....	A	Chiropractic manipulation	0.65	0.30	0.17	0.01	0.96	0.83	000
98942	.....	A	Chiropractic manipulation	0.87	0.36	0.23	0.02	1.25	1.12	000
98943	.....	N	Chiropractic manipulation	+0.40	0.24	0.16	0.01	0.65	0.57	XXX
98960	.....	N	Self-mgmt educ & train, 1 pt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
98961	.....	N	Self-mgmt educ/train, 2-4 pt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
98962	.....	N	Self-mgmt educ/train, 5-8 pt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99000	.....	B	Specimen handling	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99001	.....	B	Specimen handling	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99002	.....	B	Device handling	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99024	.....	B	Postop follow-up visit	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99026	.....	N	In-hospital on call service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99027	.....	N	Out-of-hosp on call service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99050	.....	B	Medical services after hrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99051	.....	B	Med serv, eve/wkend/holiday	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99053	.....	B	Med serv 10pm-8am, 24 hr fac	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99056	.....	B	Med service out of office	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99058	.....	B	Office emergency care	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99060	.....	B	Out of office emerg med serv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99070	.....	B	Special supplies	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99071	.....	B	Patient education materials	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99075	.....	N	Medical testimony	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99078	.....	B	Group health education	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99080	.....	B	Special reports or forms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99082	.....	C	Unusual physician travel	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99090	.....	B	Computer data analysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99091	.....	B	Collect/review data from pt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99100	.....	B	Special anesthesia service	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99116	.....	B	Anesthesia with hypothermia	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99135	.....	B	Special anesthesia procedure	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99140	.....	B	Emergency anesthesia	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99143	.....	C	Mod cs by same phys, < 5 yrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99144	.....	C	Mod cs by same phys, 5 yrs +	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99145	.....	C	Mod cs by same phys add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99148	.....	C	Mod cs diff phys < 5 yrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99149	.....	C	Mod cs diff phys 5 yrs +	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99150	.....	C	Mod cs diff phys add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99170	.....	A	Anogenital exam, child	1.75	1.77	0.55	0.08	3.60	2.38	000
99172	.....	N	Ocular function screen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99173	.....	N	Visual acuity screen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99175	.....	A	Induction of vomiting	0.00	1.39	NA	0.10	1.49	NA	XXX
99183	.....	A	Hyperbaric oxygen therapy	2.34	3.25	0.72	0.16	5.75	3.22	XXX
99185	.....	A	Regional hypothermia	0.00	0.64	NA	0.04	0.68	NA	XXX
99186	.....	A	Total body hypothermia	0.00	1.79	NA	0.45	2.24	NA	XXX
99190	.....	X	Special pump services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99191	.....	X	Special pump services	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
99192	.....	X	Special pump services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99195	.....	A	Phlebotomy	0.00	0.44	NA	0.02	0.46	NA	XXX
99199	.....	C	Special service/proc/report	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99201	.....	A	Office/outpatient visit, new	0.45	0.49	0.15	0.03	0.97	0.63	XXX
99202	.....	A	Office/outpatient visit, new	0.88	0.79	0.31	0.05	1.72	1.24	XXX
99203	.....	A	Office/outpatient visit, new	1.34	1.13	0.48	0.09	2.56	1.91	XXX
99204	.....	A	Office/outpatient visit, new	2.00	1.50	0.71	0.12	3.62	2.83	XXX
99205	.....	A	Office/outpatient visit, new	2.67	1.78	0.95	0.15	4.60	3.77	XXX
99211	.....	A	Office/outpatient visit, est	0.17	0.39	0.06	0.01	0.57	0.24	XXX
99212	.....	A	Office/outpatient visit, est	0.45	0.54	0.16	0.03	1.02	0.64	XXX
99213	.....	A	Office/outpatient visit, est	0.67	0.69	0.24	0.03	1.39	0.94	XXX
99214	.....	A	Office/outpatient visit, est	1.10	1.03	0.41	0.05	2.18	1.56	XXX
99215	.....	A	Office/outpatient visit, est	1.77	1.32	0.65	0.08	3.17	2.50	XXX
99217	.....	A	Observation care discharge	1.28	NA	0.53	0.06	NA	1.87	XXX
99218	.....	A	Observation care	1.28	NA	0.44	0.06	NA	1.78	XXX
99219	.....	A	Observation care	2.14	NA	0.72	0.10	NA	2.96	XXX
99220	.....	A	Observation care	2.99	NA	1.03	0.14	NA	4.16	XXX
99221	.....	A	Initial hospital care	1.28	NA	0.45	0.07	NA	1.80	XXX
99222	.....	A	Initial hospital care	2.14	NA	0.74	0.10	NA	2.98	XXX
99223	.....	A	Initial hospital care	2.99	NA	1.03	0.13	NA	4.15	XXX
99231	.....	A	Subsequent hospital care	0.64	NA	0.23	0.03	NA	0.90	XXX
99232	.....	A	Subsequent hospital care	1.06	NA	0.37	0.04	NA	1.47	XXX
99233	.....	A	Subsequent hospital care	1.51	NA	0.52	0.06	NA	2.09	XXX
99234	.....	A	Observ/hosp same date	2.56	NA	0.89	0.13	NA	3.58	XXX
99235	.....	A	Observ/hosp same date	3.41	NA	1.15	0.16	NA	4.72	XXX
99236	.....	A	Observ/hosp same date	4.26	NA	1.44	0.19	NA	5.89	XXX
99238	.....	A	Hospital discharge day	1.28	NA	0.54	0.05	NA	1.87	XXX
99239	.....	A	Hospital discharge day	1.75	NA	0.73	0.07	NA	2.55	XXX
99241	.....	A	Office consultation	0.64	0.64	0.22	0.05	1.33	0.91	XXX
99242	.....	A	Office consultation	1.29	1.04	0.46	0.10	2.43	1.85	XXX
99243	.....	A	Office consultation	1.72	1.39	0.63	0.13	3.24	2.48	XXX
99244	.....	A	Office consultation	2.58	1.83	0.92	0.16	4.57	3.66	XXX
99245	.....	A	Office consultation	3.42	2.28	1.24	0.21	5.91	4.87	XXX
99251	.....	A	Initial inpatient consult	0.66	NA	0.24	0.05	NA	0.95	XXX
99252	.....	A	Initial inpatient consult	1.32	NA	0.50	0.09	NA	1.91	XXX
99253	.....	A	Initial inpatient consult	1.82	NA	0.68	0.11	NA	2.61	XXX
99254	.....	A	Initial inpatient consult	2.64	NA	0.98	0.13	NA	3.75	XXX
99255	.....	A	Initial inpatient consult	3.64	NA	1.35	0.18	NA	5.17	XXX
99281	.....	A	Emergency dept visit	0.33	NA	0.09	0.02	NA	0.44	XXX
99282	.....	A	Emergency dept visit	0.55	NA	0.14	0.04	NA	0.73	XXX
99283	.....	A	Emergency dept visit	1.24	NA	0.31	0.09	NA	1.64	XXX
99284	.....	A	Emergency dept visit	1.95	NA	0.47	0.14	NA	2.56	XXX
99285	.....	A	Emergency dept visit	3.06	NA	0.72	0.23	NA	4.01	XXX
99288	.....	B	Direct advanced life support	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99289	.....	A	Ped crit care transport	4.79	NA	1.45	0.24	NA	6.48	XXX
99290	.....	A	Ped crit care transport addl	2.40	NA	0.81	0.12	NA	3.33	ZZZ
99291	.....	A	Critical care, first hour	3.99	2.58	1.28	0.21	6.78	5.48	XXX
99292	.....	A	Critical care, add'l 30 min	2.00	0.90	0.64	0.11	3.01	2.75	ZZZ
99293	.....	A	Ped critical care, initial	15.98	NA	4.76	1.12	NA	21.86	XXX
99294	.....	A	Ped critical care, subseq	7.99	NA	2.41	0.45	NA	10.85	XXX
99295	.....	A	Neonate crit care, initial	18.46	NA	5.39	1.16	NA	25.01	XXX
99296	.....	A	Neonate critical care subseq	7.99	NA	2.55	0.32	NA	10.86	XXX
99298	.....	A	Ic for lbw infant < 1500 gm	2.75	NA	0.93	0.17	NA	3.85	XXX
99299	.....	A	Ic, lbw infant 1500-2500 gm	2.50	NA	0.86	0.16	NA	3.52	XXX
99300	.....	A	Ic, infant pbw 2501-5000 gm	2.40	NA	0.84	2.40	NA	5.64	XXX
99304	.....	A	Nursing facility care, init	1.20	0.49	0.49	0.05	1.74	1.74	XXX
99305	.....	A	Nursing facility care, init	1.61	0.63	0.63	0.07	2.31	2.31	XXX
99306	.....	A	Nursing facility care, init	2.01	0.75	0.75	0.09	2.85	2.85	XXX
99307	.....	A	Nursing fac care, subseq	0.60	0.27	0.27	0.03	0.90	0.90	XXX
99308	.....	A	Nursing fac care, subseq	1.00	0.45	0.45	0.04	1.49	1.49	XXX
99309	.....	A	Nursing fac care, subseq	1.42	0.62	0.62	0.06	2.10	2.10	XXX
99310	.....	A	Nursing fac care, subseq	1.77	0.78	0.78	0.08	2.63	2.63	XXX
99315	.....	A	Nursing fac discharge day	1.13	0.45	0.45	0.05	1.63	1.63	XXX
99316	.....	A	Nursing fac discharge day	1.50	0.59	0.59	0.06	2.15	2.15	XXX
99318	.....	A	Annual nursing fac assessmnt	1.20	0.49	0.49	0.05	1.74	1.74	XXX
99324	.....	A	Domicil/r-home visit new pat	1.01	0.49	0.38	0.05	1.55	1.44	XXX
99325	.....	A	Domicil/r-home visit new pat	1.52	0.68	0.55	0.07	2.27	2.14	XXX
99326	.....	A	Domicil/r-home visit new pat	2.27	0.92	0.78	0.10	3.29	3.15	XXX
99327	.....	A	Domicil/r-home visit new pat	3.03	1.17	1.05	0.13	4.33	4.21	XXX
99328	.....	A	Domicil/r-home visit new pat	3.78	1.42	1.31	0.16	5.36	5.25	XXX
99334	.....	A	Domicil/r-home visit est pat	0.76	0.40	0.26	0.04	1.20	1.06	XXX
99335	.....	A	Domicil/r-home visit est pat	1.26	0.58	0.43	0.06	1.90	1.75	XXX
99336	.....	A	Domicil/r-home visit est pat	2.02	0.82	0.66	0.09	2.93	2.77	XXX
99337	.....	A	Domicil/r-home visit est pat	3.03	1.15	0.98	0.13	4.31	4.14	XXX
99339	.....	B	Domicil/r-home care supervis	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
99340	.....	I	Domicil/r-home care supervis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99341	.....	A	Home visit, new patient	1.01	0.48	NA	0.05	1.54	NA	XXX
99342	.....	A	Home visit, new patient	1.52	0.68	NA	0.07	2.27	NA	XXX
99343	.....	A	Home visit, new patient	2.27	0.94	NA	0.10	3.31	NA	XXX
99344	.....	A	Home visit, new patient	3.03	1.18	NA	0.13	4.34	NA	XXX
99345	.....	A	Home visit, new patient	3.78	1.43	NA	0.16	5.37	NA	XXX
99347	.....	A	Home visit, est patient	0.76	0.40	NA	0.04	1.20	NA	XXX
99348	.....	A	Home visit, est patient	1.26	0.58	NA	0.06	1.90	NA	XXX
99349	.....	A	Home visit, est patient	2.02	0.83	NA	0.09	2.94	NA	XXX
99350	.....	A	Home visit, est patient	3.03	1.18	NA	0.13	4.34	NA	XXX
99354	.....	A	Prolonged service, office	1.77	0.77	0.66	0.08	2.62	2.51	ZZZ
99355	.....	A	Prolonged service, office	1.77	0.75	0.62	0.07	2.59	2.46	ZZZ
99356	.....	A	Prolonged service, inpatient	1.71	NA	0.62	0.07	NA	2.40	ZZZ
99357	.....	A	Prolonged service, inpatient	1.71	NA	0.63	0.08	NA	2.42	ZZZ
99358	.....	B	Prolonged serv, w/o contact	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99359	.....	B	Prolonged serv, w/o contact	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99360	.....	X	Physician standby services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99361	.....	B	Physician/team conference	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99362	.....	B	Physician/team conference	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99371	.....	B	Physician phone consultation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99372	.....	B	Physician phone consultation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99373	.....	B	Physician phone consultation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99374	.....	B	Home health care supervision	+1.10	0.70	0.42	0.05	1.85	1.57	XXX
99375	.....	I	Home health care supervision	+1.73	1.55	1.55	0.07	3.35	3.35	XXX
99377	.....	B	Hospice care supervision	+1.10	0.70	0.42	0.05	1.85	1.57	XXX
99378	.....	I	Hospice care supervision	+1.73	1.95	1.95	0.07	3.75	3.75	XXX
99379	.....	B	Nursing fac care supervision	+1.10	0.70	0.42	0.04	1.84	1.56	XXX
99380	.....	B	Nursing fac care supervision	+1.73	0.99	0.66	0.06	2.78	2.45	XXX
99381	.....	N	Prev visit, new, infant	+1.19	1.50	0.45	0.05	2.74	1.69	XXX
99382	.....	N	Prev visit, new, age 1-4	+1.36	1.54	0.52	0.05	2.95	1.93	XXX
99383	.....	N	Prev visit, new, age 5-11	+1.36	1.48	0.52	0.05	2.89	1.93	XXX
99384	.....	N	Prev visit, new, age 12-17	+1.53	1.55	0.59	0.06	3.14	2.18	XXX
99385	.....	N	Prev visit, new, age 18-39	+1.53	1.55	0.59	0.06	3.14	2.18	XXX
99386	.....	N	Prev visit, new, age 40-64	+1.88	1.75	0.72	0.07	3.70	2.67	XXX
99387	.....	N	Prev visit, new, 65 & over	+2.06	1.88	0.79	0.07	4.01	2.92	XXX
99391	.....	N	Prev visit, est, infant	+1.02	1.02	0.39	0.04	2.08	1.45	XXX
99392	.....	N	Prev visit, est, age 1-4	+1.19	1.09	0.45	0.05	2.33	1.69	XXX
99393	.....	N	Prev visit, est, age 5-11	+1.19	1.06	0.45	0.05	2.30	1.69	XXX
99394	.....	N	Prev visit, est, age 12-17	+1.36	1.13	0.52	0.05	2.54	1.93	XXX
99395	.....	N	Prev visit, est, age 18-39	+1.36	1.16	0.52	0.05	2.57	1.93	XXX
99396	.....	N	Prev visit, est, age 40-64	+1.53	1.25	0.59	0.06	2.84	2.18	XXX
99397	.....	N	Prev visit, est, 65 & over	+1.71	1.36	0.66	0.06	3.13	2.43	XXX
99401	.....	N	Preventive counseling, indiv	+0.48	0.62	0.19	0.01	1.11	0.68	XXX
99402	.....	N	Preventive counseling, indiv	+0.98	0.87	0.37	0.02	1.87	1.37	XXX
99403	.....	N	Preventive counseling, indiv	+1.46	1.09	0.56	0.04	2.59	2.06	XXX
99404	.....	N	Preventive counseling, indiv	+1.95	1.32	0.75	0.05	3.32	2.75	XXX
99411	.....	N	Preventive counseling, group	+0.15	0.18	0.06	0.01	0.34	0.22	XXX
99412	.....	N	Preventive counseling, group	+0.25	0.25	0.10	0.01	0.51	0.36	XXX
99420	.....	N	Health risk assessment test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99429	.....	N	Unlisted preventive service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99431	.....	A	Initial care, normal newborn	1.17	NA	0.38	0.05	NA	1.60	XXX
99432	.....	A	Newborn care, not in hosp	1.26	0.93	0.40	0.07	2.26	1.73	XXX
99433	.....	A	Normal newborn care/hospital	0.62	NA	0.20	0.02	NA	0.84	XXX
99435	.....	A	Newborn discharge day hosp	1.50	NA	0.59	0.06	NA	2.15	XXX
99436	.....	A	Attendance, birth	1.50	NA	0.47	0.06	NA	2.03	XXX
99440	.....	A	Newborn resuscitation	2.93	NA	0.93	0.12	NA	3.98	XXX
99450	.....	N	Life/disability evaluation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99455	.....	R	Disability examination	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99456	.....	R	Disability examination	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99499	.....	C	Unlisted e&m service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99500	.....	I	Home visit, prenatal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99501	.....	I	Home visit, postnatal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99502	.....	I	Home visit, nb care	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99503	.....	I	Home visit, resp therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99504	.....	I	Home visit mech ventilator	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99505	.....	I	Home visit, stoma care	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99506	.....	I	Home visit, im injection	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99507	.....	I	Home visit, cath maintain	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99509	.....	I	Home visit day life activity	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99510	.....	I	Home visit, sing/m/fam couns	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99511	.....	I	Home visit, fecal/enema mgmt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99512	.....	I	Home visit for hemodialysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99600	.....	I	Home visit nos	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99601	.....	I	Home infusion/visit, 2 hrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99602	.....	I	Home infusion, each add'l hr	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
A4890	.....	R	Repair/maint cont hemo equip	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0150	.....	R	Comprehensve oral evaluation	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D0240	.....	R	Intraoral occlusal film	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D0250	.....	R	Extraoral first film	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D0260	.....	R	Extraoral ea additional film	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D0270	.....	R	Dental bitewing single film	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D0272	.....	R	Dental bitewings two films	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D0274	.....	R	Dental bitewings four films	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D0277	.....	R	Vert bitewings-sev to eight	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0416	.....	R	Viral culture	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0421	.....	R	Gen tst suscept oral disease	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0431	.....	R	Diag tst detect mucos abnorm	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0460	.....	R	Pulp vitality test	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D0472	.....	R	Gross exam, prep & report	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0473	.....	R	Micro exam, prep & report	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0474	.....	R	Micro w exam of surg margins	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0475	.....	R	Decalcification procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0476	.....	R	Spec stains for microorganis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0477	.....	R	Spec stains not for microorg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0478	.....	R	Immunohistochemical stains	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0479	.....	R	Tissue in-situ hybridization	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0480	.....	R	Cytopath smear prep & report	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0481	.....	R	Electron microscopy diagnost	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0482	.....	R	Direct immunofluorescence	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0483	.....	R	Indirect immunofluorescence	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0484	.....	R	Consult slides prep elsewher	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0485	.....	R	Consult inc prep of slides	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0502	.....	R	Other oral pathology procedu	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D0999	.....	R	Unspecified diagnostic proce	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D1510	.....	R	Space maintainer fxd unilat	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D1515	.....	R	Fixed bilat space maintainer	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D1520	.....	R	Remove unilat space maintain	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D1525	.....	R	Remove bilat space maintain	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D1550	.....	R	Recement space maintainer	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D2999	.....	R	Dental unspec restorative pr	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D3460	.....	R	Endodontic endosseous implan	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D3999	.....	R	Endodontic procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D4260	.....	R	Osseous surgery per quadrant	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D4263	.....	R	Bone replce graft first site	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D4264	.....	R	Bone replce graft each add	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D4268	.....	R	Surgical revision procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D4270	.....	R	Pedicle soft tissue graft pr	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D4271	.....	R	Free soft tissue graft proc	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D4273	.....	R	Subepithelial tissue graft	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D4355	.....	R	Full mouth debridement	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D4381	.....	R	Localized delivery antimicro	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D5911	.....	R	Facial moulage sectional	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D5912	.....	R	Facial moulage complete	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D5951	.....	R	Feeding aid	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D5983	.....	R	Radiation applicator	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D5984	.....	R	Radiation shield	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D5985	.....	R	Radiation cone locator	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D5987	.....	R	Commissure splint	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D6920	.....	R	Dental connector bar	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D7111	.....	R	Extraction coronal remnants	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D7140	.....	R	Extraction erupted tooth/exr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D7210	.....	R	Rem imp tooth w mucoper flp	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D7220	.....	R	Impact tooth remov soft tiss	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D7230	.....	R	Impact tooth remov part bony	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D7240	.....	R	Impact tooth remov comp bony	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D7241	.....	R	Impact tooth rem bony w/comp	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D7250	.....	R	Tooth root removal	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D7260	.....	R	Oral antral fistula closure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D7261	.....	R	Primary closure sinus perf	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D7283	.....	R	Place device impacted tooth	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D7288	.....	R	Brush biopsy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D7291	.....	R	Transseptal fiberotomy	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D7321	.....	R	Alveoloplasty not w/extracts	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D7511	.....	R	Incision/drain abscess intra	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D7521	.....	R	Incision/drain abscess extra	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D7940	.....	R	Reshaping bone orthognathic	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D9110	.....	R	Tx dental pain minor proc	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D9230	.....	R	Analgesia	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D9248	.....	R	Sedation (non-iv)	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D9630	.....	R	Other drugs/medicaments	0.00	0.00	0.00	0.00	0.00	0.00	YYY

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
D9930	.....	R	Treatment of complications	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D9940	.....	R	Dental occlusal guard	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D9950	.....	R	Occlusion analysis	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D9951	.....	R	Limited occlusal adjustment	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D9952	.....	R	Complete occlusal adjustment	0.00	0.00	0.00	0.00	0.00	0.00	YYY
G0008 ...	.....	X	Admin influenza virus vac	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0009 ...	.....	X	Admin pneumococcal vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0010 ...	.....	X	Admin hepatitis b vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0027 ...	.....	X	Semen analysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0101 ...	.....	A	CA screen;pelvic/breast exam	0.45	0.52	0.17	0.02	0.99	0.64	XXX
G0102 ...	.....	A	Prostate ca screening; dre	0.17	0.39	0.06	0.01	0.57	0.24	XXX
G0103 ...	.....	X	Psa, total screening	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0104 ...	.....	A	CA screen;flexi sigmoidscope	0.96	2.28	0.50	0.08	3.32	1.54	000
G0105 ...	53	A	Colorectal scrn; hi risk ind	0.96	2.28	0.50	0.08	3.32	1.54	000
G0105 ...	.....	A	Colorectal scrn; hi risk ind	3.69	6.16	1.47	0.30	10.15	5.46	000
G0106 ...	26	A	Colon CA screen;barium enema	0.99	0.32	0.32	0.04	1.35	1.35	XXX
G0106 ...	TC	A	Colon CA screen;barium enema	0.00	2.24	NA	0.13	2.37	NA	XXX
G0106 ...	.....	A	Colon CA screen;barium enema	0.99	2.56	NA	0.17	3.72	NA	XXX
G0107 ...	.....	X	CA screen; fecal blood test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0108 ...	.....	A	Diab manage trn per indiv	0.00	0.83	NA	0.01	0.84	NA	XXX
G0109 ...	.....	A	Diab manage trn ind/group	0.00	0.48	NA	0.01	0.49	NA	XXX
G0117 ...	.....	T	Glaucoma scrn hgh risk direc	0.45	0.72	0.19	0.01	1.18	0.65	XXX
G0118 ...	.....	T	Glaucoma scrn hgh risk direc	0.17	0.53	0.06	0.01	0.71	0.24	XXX
G0120 ...	26	A	Colon ca scrn; barium enema	0.99	0.32	0.32	0.04	1.35	1.35	XXX
G0120 ...	TC	A	Colon ca scrn; barium enema	0.00	2.24	NA	0.13	2.37	NA	XXX
G0120 ...	.....	A	Colon ca scrn; barium enema	0.99	2.56	NA	0.17	3.72	NA	XXX
G0121 ...	53	A	Colon ca scrn not hi rsk ind	0.96	2.28	0.50	0.08	3.32	1.54	000
G0121 ...	.....	A	Colon ca scrn not hi rsk ind	3.69	6.16	1.47	0.30	10.15	5.46	000
G0122 ...	26	N	Colon ca scrn; barium enema	+0.99	0.38	0.38	0.05	1.42	1.42	XXX
G0122 ...	TC	N	Colon ca scrn; barium enema	+0.00	2.20	2.20	0.13	2.33	2.33	XXX
G0122 ...	.....	N	Colon ca scrn; barium enema	+0.99	2.58	2.58	0.18	3.75	3.75	XXX
G0123 ...	.....	X	Screen cerv/vag thin layer	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0124 ...	.....	A	Screen c/v thin layer by MD	0.42	0.15	0.15	0.02	0.59	0.59	XXX
G0127 ...	.....	R	Trim nail(s)	0.17	0.25	0.07	0.01	0.43	0.25	000
G0128 ...	.....	R	CORF skilled nursing service	0.08	0.03	0.03	0.01	0.12	0.12	XXX
G0130 ...	26	A	Single energy x-ray study	0.22	0.07	0.07	0.01	0.30	0.30	XXX
G0130 ...	TC	A	Single energy x-ray study	0.00	0.80	NA	0.05	0.85	NA	XXX
G0130 ...	.....	A	Single energy x-ray study	0.22	0.87	NA	0.06	1.15	NA	XXX
G0141 ...	.....	A	Scr c/v cyto,autosys and md	0.42	0.15	0.15	0.02	0.59	0.59	XXX
G0143 ...	.....	X	Scr c/v cyto,thinlayer,rescr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0144 ...	.....	X	Scr c/v cyto,thinlayer,rescr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0145 ...	.....	X	Scr c/v cyto,thinlayer,rescr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0147 ...	.....	X	Scr c/v cyto, automated sys	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0148 ...	.....	X	Scr c/v cyto, autosys, rescr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0166 ...	.....	A	Extrnl counterpulse, per tx	0.07	3.58	0.03	0.01	3.66	0.11	XXX
G0168 ...	.....	A	Wound closure by adhesive	0.45	1.94	0.22	0.03	2.42	0.70	000
G0173 ...	.....	X	Linear acc stereo radsur com	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0175 ...	.....	X	OPPS Service,sched team conf	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0176 ...	.....	X	OPPS/PHP;activity therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0177 ...	.....	X	OPPS/PHP; train & educ serv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0179 ...	.....	A	MD recertification HHA PT	0.45	1.03	NA	0.02	1.50	NA	XXX
G0180 ...	.....	A	MD certification HHA patient	0.67	1.26	NA	0.03	1.96	NA	XXX
G0181 ...	.....	A	Home health care supervision	1.73	1.48	NA	0.07	3.28	NA	XXX
G0182 ...	.....	A	Hospice care supervision	1.73	1.66	NA	0.07	3.46	NA	XXX
G0186 ...	.....	C	Dstry eye lesn,fdr vssl tech	0.00	0.00	0.00	0.00	0.00	0.00	YYY
G0202 ...	26	A	Screeningmammographydigital	0.70	0.23	0.23	0.03	0.96	0.96	XXX
G0202 ...	TC	A	Screeningmammographydigital	0.00	2.55	NA	0.07	2.62	NA	XXX
G0202 ...	.....	A	Screeningmammographydigital	0.70	2.78	NA	0.10	3.58	NA	XXX
G0204 ...	26	A	Diagnosticmammographydigital	0.87	0.28	0.28	0.04	1.19	1.19	XXX
G0204 ...	TC	A	Diagnosticmammographydigital	0.00	2.51	NA	0.07	2.58	NA	XXX
G0204 ...	.....	A	Diagnosticmammographydigital	0.87	2.79	NA	0.11	3.77	NA	XXX
G0206 ...	26	A	Diagnosticmammographydigital	0.70	0.23	0.23	0.03	0.96	0.96	XXX
G0206 ...	TC	A	Diagnosticmammographydigital	0.00	2.03	NA	0.06	2.09	NA	XXX
G0206 ...	.....	A	Diagnosticmammographydigital	0.70	2.26	NA	0.09	3.05	NA	XXX
G0219 ...	26	N	PET img wholbod melano nonco	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0219 ...	TC	N	PET img wholbod melano nonco	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0219 ...	.....	N	PET img wholbod melano nonco	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0235 ...	26	N	PET not otherwise specified	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0235 ...	TC	N	PET not otherwise specified	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0235 ...	.....	N	PET not otherwise specified	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0237 ...	.....	A	Therapeutic procd strg endur	0.00	0.47	NA	0.02	0.49	NA	XXX
G0238 ...	.....	A	Oth resp proc, indiv	0.00	0.49	NA	0.02	0.51	NA	XXX
G0239 ...	.....	A	Oth resp proc, group	0.00	0.33	NA	0.02	0.35	NA	XXX
G0243 ...	.....	X	Multisour photon stero treat	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0245 ...	.....	R	Initial foot exam pt lops	0.88	0.79	0.31	0.04	1.71	1.23	XXX

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[3] +Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
G0246 ...	.....	R	Followup eval of foot pt lop	0.45	0.54	0.16	0.02	1.01	0.63	XXX
G0247 ...	.....	R	Routine footcare pt w lops	0.50	0.52	0.21	0.02	1.04	0.73	ZZZ
G0248 ...	.....	R	Demonstrate use home inr mon	0.00	6.63	NA	0.01	6.64	NA	XXX
G0249 ...	.....	R	Provide test material,equipm	0.00	3.97	NA	0.01	3.98	NA	XXX
G0250 ...	.....	R	MD review interpret of test	0.18	0.06	0.06	0.01	0.25	0.25	XXX
G0251 ...	.....	E	Linear acc based stero radio	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0255 ...	26	N	Current percep threshold tst	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0255 ...	TC	N	Current percep threshold tst	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0255 ...	.....	N	Current percep threshold tst	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0257 ...	.....	E	Unsched dialysis ESRD pt hos	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0259 ...	.....	E	Inject for sacroiliac joint	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0260 ...	.....	E	Inj for sacroiliac jt anesth	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0265 ...	.....	X	Cryopresevation Freeze+stora	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0266 ...	.....	X	Thawing + expansion froz cel	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0267 ...	.....	X	Bone marrow or psc harvest	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0268 ...	.....	A	Removal of impacted wax md	0.61	0.63	0.24	0.02	1.26	0.87	000
G0269 ...	.....	B	Occlusive device in vein art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0270 ...	.....	A	MNT subs tx for change dx	0.00	0.47	NA	0.01	0.48	NA	XXX
G0271 ...	.....	A	Group MNT 2 or more 30 mins	0.00	0.18	NA	0.01	0.19	NA	XXX
G0275 ...	.....	A	Renal angio, cardiac cath	0.25	NA	0.10	0.01	NA	0.36	ZZZ
G0278 ...	.....	A	Iliac art angio,cardiac cath	0.25	NA	0.10	0.01	NA	0.36	ZZZ
G0281 ...	.....	A	Elec stim unattend for press	0.18	0.11	NA	0.01	0.30	NA	XXX
G0282 ...	.....	N	Elect stim wound care not pd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0283 ...	.....	A	Elec stim other than wound	0.18	0.11	NA	0.01	0.30	NA	XXX
G0288 ...	.....	A	Recon, CTA for surg plan	0.00	10.64	NA	0.18	10.82	NA	XXX
G0289 ...	.....	A	Arthro, loose body + chondro	1.48	NA	0.80	0.26	NA	2.54	ZZZ
G0290 ...	.....	E	Drug-eluting stents, single	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0291 ...	.....	E	Drug-eluting stents,each add	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0293 ...	.....	E	Non-cov surg proc,clin trial	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0294 ...	.....	E	Non-cov proc, clinical trial	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0295 ...	.....	N	Electromagnetic therapy onc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0297 ...	.....	X	Insert single chamber/cd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0298 ...	.....	X	Insert dual chamber/cd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0299 ...	.....	X	Inser/repos single icd+leads	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0300 ...	.....	X	Insert reposit lead dual+gen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0302 ...	.....	X	Pre-op service LVRS complete	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0303 ...	.....	X	Pre-op service LVRS 10-15dos	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0304 ...	.....	X	Pre-op service LVRS 1-9 dos	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0305 ...	.....	X	Post op service LVRS min 6	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0306 ...	.....	X	CBC/diffwbc w/o platelet	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0307 ...	.....	X	CBC without platelet	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0308 ...	.....	A	ESRD related svc 4+mo < 2yrs	12.74	8.56	8.56	0.42	21.72	21.72	XXX
G0309 ...	.....	A	ESRD related svc 2-3mo <2yrs	10.61	7.12	7.12	0.36	18.09	18.09	XXX
G0310 ...	.....	A	ESRD related svc 1 vst <2yrs	8.49	5.70	5.70	0.28	14.47	14.47	XXX
G0311 ...	.....	A	ESRD related svs 4+mo 2-11yr	9.73	4.73	4.73	0.34	14.80	14.80	XXX
G0312 ...	.....	A	ESRD relate svs 2-3 mo 2-11y	8.11	3.93	3.93	0.29	12.33	12.33	XXX
G0313 ...	.....	A	ESRD related svs 1 mon 2-11y	6.49	3.15	3.15	0.22	9.86	9.86	XXX
G0314 ...	.....	A	ESRD related svs 4+ mo 12-19	8.28	4.43	4.43	0.27	12.98	12.98	XXX
G0315 ...	.....	A	ESRD related svs 2-3mo/12-19	6.90	3.68	3.68	0.23	10.81	10.81	XXX
G0316 ...	.....	A	ESRD related svs 1vis/12-19y	5.52	2.95	2.95	0.17	8.64	8.64	XXX
G0317 ...	.....	A	ESRD related svs 4+mo 20+yrs	5.09	2.87	2.87	0.17	8.13	8.13	XXX
G0318 ...	.....	A	ESRD related svs 2-3 mo 20+y	4.24	2.39	2.39	0.14	6.77	6.77	XXX
G0319 ...	.....	A	ESRD related svs 1visit 20+y	3.39	1.91	1.91	0.11	5.41	5.41	XXX
G0320 ...	.....	A	ESD related svs home undr 2	10.61	7.12	7.12	0.36	18.09	18.09	XXX
G0321 ...	.....	A	ESRDrelatedsvs home mo 2-11y	8.11	3.93	3.93	0.29	12.33	12.33	XXX
G0322 ...	.....	A	ESRD related svs hom mo12-19	6.90	3.68	3.68	0.23	10.81	10.81	XXX
G0323 ...	.....	A	ESRD related svs home mo 20+	4.24	2.39	2.39	0.14	6.77	6.77	XXX
G0324 ...	.....	A	ESRD relate svs home/dy <2yr	0.35	0.24	0.24	0.01	0.60	0.60	XXX
G0325 ...	.....	A	ESRD relate home/day/ 2-11yr	0.23	0.12	0.12	0.01	0.36	0.36	XXX
G0326 ...	.....	A	ESRD relate home/dy 12-19yr	0.27	0.13	0.13	0.01	0.41	0.41	XXX
G0327 ...	.....	A	ESRD relate home/dy 20+yrs	0.14	0.08	0.08	0.01	0.23	0.23	XXX
G0328 ...	.....	X	Fecal blood scrn immunoassay	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0329 ...	.....	A	Electromagntic tx for ulcers	0.06	0.14	0.02	0.01	0.21	0.09	XXX
G0337 ...	.....	X	Hospice evaluation preelecti	+1.34	0.51	0.51	0.09	1.94	1.94	XXX
G0339 ...	.....	C	Robot lin-radsurg com, first	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0340 ...	.....	C	Robt lin-radsurg fractx 2-5	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0341 ...	.....	A	Percutaneous islet celltrans	6.98	5.75	2.60	0.48	13.21	10.06	000
G0342 ...	.....	A	Laparoscopy islet cell trans	11.92	NA	5.31	1.46	NA	18.69	090
G0343 ...	.....	A	Laparotomy islet cell transp	19.85	NA	8.78	2.06	NA	30.69	090
G0344 ...	.....	A	Initial preventive exam	1.34	1.13	0.48	0.10	2.57	1.92	XXX
G0364 ...	.....	A	Bone marrow aspirate &biopsy	0.16	0.14	0.06	0.04	0.34	0.26	ZZZ
G0365 ...	26	A	Vessel mapping hemo access	0.25	0.09	0.09	0.02	0.36	0.36	XXX
G0365 ...	TC	A	Vessel mapping hemo access	0.00	3.91	NA	0.23	4.14	NA	XXX
G0365 ...	.....	A	Vessel mapping hemo access	0.25	4.00	NA	0.25	4.50	NA	XXX
G0366 ...	.....	A	EKG for initial prevent exam	0.17	0.51	NA	0.03	0.71	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
G0367 ...	.....	A	EKG tracing for initial prev	0.00	0.45	NA	0.02	0.47	NA	XXX
G0368 ...	.....	A	EKG interpret & report preve	0.17	0.06	0.06	0.01	0.24	0.24	XXX
G0372 ...	.....	A	MD service required for PMD	0.17	0.39	0.06	0.01	0.57	0.24	XXX
G0375 ...	.....	A	Smoke/tobacco counselng 3-10	0.24	0.09	0.09	0.01	0.34	0.34	XXX
G0376 ...	.....	A	Smoke/tobacco counseling >10	0.48	0.18	0.17	0.01	0.67	0.66	XXX
G0378 ...	.....	X	Hospital observation per hr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0379 ...	.....	X	Direct admit hospital observ	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G3001 ...	.....	X	Admin + supply, tositumomab	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9001 ...	.....	X	MCCD, initial rate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9002 ...	.....	X	MCCD,maintenance rate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9003 ...	.....	X	MCCD, risk adj hi, initial	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9004 ...	.....	X	MCCD, risk adj lo, initial	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9005 ...	.....	X	MCCD, risk adj, maintenance	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9006 ...	.....	X	MCCD, Home monitoring	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9007 ...	.....	X	MCCD, sch team conf	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9008 ...	.....	X	Mccd,phys coor-care ovrsght	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9009 ...	.....	X	MCCD, risk adj, level 3	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9010 ...	.....	X	MCCD, risk adj, level 4	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9011 ...	.....	X	MCCD, risk adj, level 5	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9012 ...	.....	X	Other Specified Case Mgmt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9013 ...	.....	N	ESRD demo bundle level I	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9014 ...	.....	N	ESRD demo bundle-level II	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9016 ...	.....	N	Demo-smoking cessation coun	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9017 ...	.....	X	Amantadine HCL 100mg oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9018 ...	.....	X	Zanamivir,inhalation pwd 10m	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9019 ...	.....	X	Oseltamivir phosphate 75mg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9020 ...	.....	X	Rimantadine HCL 100mg oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9021 ...	.....	X	Chemo assess nausea vomit L1	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9022 ...	.....	X	Chemo assess nausea vomit L2	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9023 ...	.....	X	Chemo assess nausea vomit L3	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9024 ...	.....	X	Chemo assess nausea vomit L4	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9025 ...	.....	X	Chemo assessment pain level1	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9026 ...	.....	X	Chemo assessment pain level2	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9027 ...	.....	X	Chemo assessment pain level3	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9028 ...	.....	X	Chemo assessment pain level4	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9029 ...	.....	X	Chemo assess for fatigue L1	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9030 ...	.....	X	Chemo assess for fatigue L2	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9031 ...	.....	X	Chemo assess for fatigue L3	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9032 ...	.....	X	Chemo assess for fatigue L4	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9033 ...	.....	X	Amantadine HCL oral brand	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9034 ...	.....	X	Zanamivir, inh pwdr, brand	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9035 ...	.....	X	Oseltamivir phosp, brand	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9036 ...	.....	X	Rimantadine HCL, brand	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9041 ...	.....	X	Low vision rehab occupationa	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9042 ...	.....	X	Low vision rehab orient/mobi	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9043 ...	.....	X	Low vision lowvision therapi	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9044 ...	.....	X	Low vision rehabilate teache	0.00	0.00	0.00	0.00	0.00	0.00	XXX
M0064 ...	.....	A	Visit for drug monitoring	0.37	0.34	0.12	0.01	0.72	0.50	XXX
P3001	.....	A	Screening pap smear by phys	0.42	0.15	0.15	0.02	0.59	0.59	XXX
Q0035 ...	26	A	Cardiokymography	0.17	0.06	0.06	0.01	0.24	0.24	XXX
Q0035 ...	TC	A	Cardiokymography	0.00	0.39	NA	0.02	0.41	NA	XXX
Q0035 ...	.....	A	Cardiokymography	0.17	0.45	NA	0.03	0.65	NA	XXX
Q0091 ...	.....	A	Obtaining screen pap smear	0.37	0.67	0.14	0.02	1.06	0.53	XXX
Q0092 ...	.....	A	Set up port xray equipment	0.00	0.32	NA	0.01	0.33	NA	XXX
Q3001 ...	.....	C	Brachytherapy Radioelements	0.00	0.00	0.00	0.00	0.00	0.00	XXX
Q3014 ...	.....	X	Telehealth facility fee	0.00	0.00	0.00	0.00	0.00	0.00	XXX
R0070	.....	C	Transport portable x-ray	0.00	0.00	0.00	0.00	0.00	0.00	XXX
R0075	.....	C	Transport port x-ray multipl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
R0076	.....	B	Transport portable EKG	0.00	0.00	0.00	0.00	0.00	0.00	XXX
V5299	.....	R	Hearing service	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM C.—CODES WITH INTERIM RVUS

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
15040	.....	A	Harvest cultured skin graft	2.00	4.57	1.13	0.24	6.81	3.37	000
15110	.....	A	Epidrm autogrft trnk/arm/leg	9.50	10.70	7.02	1.31	21.51	17.83	090
15111	.....	A	Epidrm autogrft t/a/l add-on	1.85	1.29	0.79	0.26	3.40	2.90	ZZZ

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ADDENDUM C.—CODES WITH INTERIM RVUS—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
15115	.....	A	Epidrm a-grft face/nck/hf/g	9.81	9.25	7.37	1.15	20.21	18.33	090
15116	.....	A	Epidrm a-grft f/n/hf/g addl	2.50	1.58	1.12	0.33	4.41	3.95	ZZZ
15130	.....	A	Derm autograft, trnk/arm/leg	7.00	9.89	6.36	0.97	17.86	14.33	090
15131	.....	A	Derm autograft t/a/l add-on	1.50	1.07	0.64	0.21	2.78	2.35	ZZZ
15135	.....	A	Derm autograft face/nck/hf/g	10.50	9.90	8.15	1.23	21.63	19.88	090
15136	.....	A	Derm autograft, f/n/hf/g add	1.50	0.89	0.67	0.20	2.59	2.37	ZZZ
15150	.....	A	Cult epiderm grft t/arm/leg	8.25	8.48	6.46	1.14	17.87	15.85	090
15151	.....	A	Cult epiderm grft t/a/l addl	2.00	1.31	0.85	0.28	3.59	3.13	ZZZ
15152	.....	A	Cult epiderm graft t/a/l +%	2.50	1.56	1.06	0.35	4.41	3.91	ZZZ
15155	.....	A	Cult epiderm graft, f/n/hf/g	9.00	7.84	6.98	1.05	17.89	17.03	090
15156	.....	A	Cult epidrm grft f/n/hfg add	2.75	1.56	1.24	0.36	4.67	4.35	ZZZ
15157	.....	A	Cult epiderm grft f/n/hfg +%	3.00	1.78	1.35	0.39	5.17	4.74	ZZZ
15170	.....	A	Acell graft trunk/arms/legs	5.00	3.84	2.37	0.55	9.39	7.92	090
15171	.....	A	Acell graft t/arm/leg add-on	1.55	0.68	0.62	0.19	2.42	2.36	ZZZ
15175	.....	A	Acellular graft, f/n/hf/g	7.00	5.44	4.01	0.82	13.26	11.83	090
15176	.....	A	Acell graft, f/n/hf/g add-on	2.45	1.11	0.99	0.29	3.85	3.73	ZZZ
15300	.....	A	Apply skinallogrft, t/arm/lg	3.99	3.21	2.24	0.49	7.69	6.72	090
15301	.....	A	Apply sknallogrft t/a/l addl	1.00	0.47	0.40	0.14	1.61	1.54	ZZZ
15320	.....	A	Apply skin allogrft f/n/hf/g	4.70	3.63	2.54	0.58	8.91	7.82	090
15321	.....	A	Aply sknallogrft f/n/hfg add	1.50	0.69	0.59	0.21	2.40	2.30	ZZZ
15330	.....	A	Aply acell alogrft t/arm/leg	3.99	3.20	2.23	0.49	7.68	6.71	090
15331	.....	A	Aply acell grft t/a/l add-on	1.00	0.46	0.40	0.14	1.60	1.54	ZZZ
15335	.....	A	Apply acell graft, f/n/hf/g	4.50	3.48	2.45	0.55	8.53	7.50	090
15336	.....	A	Aply acell grft f/n/hf/g add	1.43	0.69	0.57	0.20	2.32	2.20	ZZZ
15340	.....	A	Apply cult skin substitute	3.72	4.01	2.76	0.41	8.14	6.89	010
15341	.....	A	Apply cult skin sub add-on	0.50	0.61	0.20	0.06	1.17	0.76	ZZZ
15360	.....	A	Apply cult derm sub, t/a/l	3.87	4.48	3.09	0.43	8.78	7.39	090
15361	.....	A	Aply cult derm sub t/a/l add	1.15	0.58	0.46	0.14	1.87	1.75	ZZZ
15365	.....	A	Apply cult derm sub f/n/hf/g	4.15	4.56	3.20	0.46	9.17	7.81	090
15366	.....	A	Apply cult derm f/hf/g add	1.45	0.70	0.58	0.17	2.32	2.20	ZZZ
15420	.....	A	Apply skin xgraft, f/n/hf/g	4.50	4.79	3.80	0.52	9.81	8.82	090
15421	.....	A	Apply skn xgrft f/n/hf/g add	1.50	1.32	0.62	0.21	3.03	2.33	ZZZ
15430	.....	A	Apply acellular xenograft	5.75	6.92	6.63	0.66	13.33	13.04	090
15431	.....	C	Apply acellular xgraft add	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
22010	.....	A	I&d, p-spine, c/t/cerv-thor	11.05	NA	8.91	1.73	NA	21.69	090
22015	.....	A	I&d, p-spine, l/s/ls	10.94	NA	8.85	1.71	NA	21.50	090
22523	.....	A	Percut kyphoplasty, thor	8.94	NA	5.92	1.43	NA	16.29	010
22524	.....	A	Percut kyphoplasty, lumbar	8.54	NA	5.71	1.36	NA	15.61	010
22525	.....	A	Percut kyphoplasty, add-on	4.47	NA	2.28	0.72	NA	7.47	ZZZ
28890	.....	A	High energy eswt, plantar f	3.30	5.73	2.09	0.41	9.44	5.80	090
32503	.....	A	Resect apical lung tumor	30.00	NA	15.11	4.37	NA	49.48	090
32504	.....	A	Resect apical lung tum/chest	34.80	NA	16.72	5.07	NA	56.59	090
33507	.....	A	Repair art, intramural	30.00	NA	13.68	4.05	NA	47.73	090
33548	.....	A	Restore/remodel, ventricle	37.97	NA	19.35	5.51	NA	62.83	090
33768	.....	A	Cavopulmonary shunting	8.00	NA	2.67	1.19	NA	11.86	ZZZ
33880	.....	A	Endovasc taa repr incl subcl	33.00	NA	13.51	2.74	NA	49.25	090
33881	.....	A	Endovasc taa repr w/o subcl	28.00	NA	11.99	2.32	NA	42.31	090
33883	.....	A	Insert endovasc prosth, taa	20.00	NA	9.21	2.10	NA	31.31	090
33884	.....	A	Endovasc prosth, taa, add-on	8.20	NA	2.58	0.86	NA	11.64	ZZZ
33886	.....	A	Endovasc prosth, delayed	17.00	NA	8.25	1.79	NA	27.04	090
33889	.....	A	Artery transpose/endovas taa	15.92	NA	5.19	2.17	NA	23.28	000
33891	.....	A	Car-car bp grft/endovas taa	20.00	NA	6.98	2.72	NA	29.70	000
33925	.....	A	Rpr pul art unifocal w/o cpb	29.50	NA	14.70	4.60	NA	48.80	090
33926	.....	A	Repr pul art, unifocal w/cpb	42.00	NA	17.73	6.20	NA	65.93	090
36598	.....	T	Inj w/fluor, eval cv device	0.74	2.65	2.65	0.05	3.44	3.44	000
37184	.....	A	Prim art mech thrombectomy	8.66	71.90	3.36	0.55	81.11	12.57	000
37185	.....	A	Prim art m-thrombect add-on	3.28	22.95	1.11	0.21	26.44	4.60	ZZZ
37186	.....	A	Sec art m-thrombect add-on	4.92	49.53	1.66	0.32	54.77	6.90	ZZZ
37187	.....	A	Venous mech thrombectomy	8.03	70.38	3.15	0.51	78.92	11.69	000
37188	.....	A	Venous m-thrombectomy add-on	5.71	62.15	2.37	0.37	68.23	8.45	000
37718	.....	A	Ligate/strip short leg vein	6.76	NA	4.07	0.14	NA	10.97	090
37722	.....	A	Ligate/strip long leg vein	7.79	NA	4.42	0.86	NA	13.07	090
43770	.....	A	Lap, place gastr adjust band	16.71	NA	7.73	2.18	NA	26.62	090
43771	.....	A	Lap, revise adjust gast band	19.50	NA	8.61	2.54	NA	30.65	090
43772	.....	A	Lap, remove adjust gast band	15.00	NA	6.44	1.92	NA	23.36	090
43773	.....	A	Lap, change adjust gast band	19.50	NA	8.61	2.55	NA	30.66	090
43774	.....	A	Lap remov adj gast band/port	15.00	NA	6.58	1.84	NA	23.42	090
43845	.....	A	Gastroplasty duodenal switch	31.00	10.80	10.80	4.05	45.85	45.85	090
43886	.....	A	Revise gastric port, open	4.00	NA	3.14	0.25	NA	7.39	090
43887	.....	A	Remove gastric port, open	3.95	NA	2.78	0.51	NA	7.24	090
43888	.....	A	Change gastric port, open	5.80	NA	3.77	0.70	NA	10.27	090
44180	.....	A	Lap, enterolysis	14.42	NA	6.25	1.85	NA	22.52	090
44186	.....	A	Lap, jejunostomy	9.77	NA	4.80	1.27	NA	15.84	090
44187	.....	A	Lap, ileo/jejuno-stomy	15.93	NA	8.29	1.95	NA	26.17	090
44188	.....	A	Lap, colostomy	17.61	NA	8.87	2.23	NA	28.71	090

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ADDENDUM C.—CODES WITH INTERIM RVUS—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
44213	.....	A	Lap, mobil splenic fl add-on	3.50	NA	1.22	0.44	NA	5.16	ZZZ
44227	.....	A	Lap, close enterostomy	26.50	NA	10.65	3.37	NA	40.52	090
45395	.....	A	Lap, removal of rectum	30.50	NA	13.71	3.62	NA	47.83	090
45397	.....	A	Lap, remove rectum w/pouch	34.00	NA	14.30	3.66	NA	51.96	090
45400	.....	A	Laparoscopic proctopexy	18.06	NA	7.85	2.02	NA	27.93	090
45402	.....	A	Lap proctopexy w/sig resect	25.04	NA	10.01	2.81	NA	37.86	090
45499	.....	C	Laparoscope proc, rectum	0.00	0.00	0.00	0.00	0.00	0.00	YYY
45990	.....	A	Surg dx exam, anorectal	1.80	NA	0.79	0.17	NA	2.76	000
46505	.....	A	Chemodenervation anal musc	2.86	3.05	1.97	0.14	6.05	4.97	010
46710	.....	A	Repr per/vag pouch sngl proc	16.00	NA	7.77	1.38	NA	25.15	090
46712	.....	A	Repr per/vag pouch dbl proc	34.00	NA	15.08	3.66	NA	52.74	090
50250	.....	A	Cryoablate renal mass open	19.97	NA	9.18	1.39	NA	30.54	090
50382	.....	A	Change ureter stent, percut	5.50	36.22	1.87	0.34	42.06	7.71	000
50384	.....	A	Remove ureter stent, percut	5.00	35.32	1.71	0.31	40.63	7.02	000
50387	.....	A	Change ext/int ureter stent	2.00	18.26	0.67	0.12	20.38	2.79	000
50389	.....	A	Remove renal tube w/fluoro	1.10	12.78	0.37	0.07	13.95	1.54	000
50592	.....	A	Perc rf ablate renal tumor	6.75	149.45	2.99	0.43	156.63	10.17	010
51999	.....	C	Laparoscope proc, bladder	0.00	0.00	0.00	0.00	0.00	0.00	YYY
57295	.....	A	Change vaginal graft	7.45	NA	4.44	0.91	NA	12.80	090
58110	.....	A	Bx done w/colposcopy add-on	0.77	0.55	0.31	0.09	1.41	1.17	ZZZ
61630	.....	N	Intracranial angioplasty	0.00	0.00	0.00	0.00	0.00	0.00	090
61635	.....	N	Intracran angioplsty w/stent	0.00	0.00	0.00	0.00	0.00	0.00	090
61640	.....	N	Dilate ic vasospasm, init	0.00	0.00	0.00	0.00	0.00	0.00	000
61641	.....	N	Dilate ic vasospasm add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
61642	.....	N	Dilate ic vasospasm add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
64650	.....	A	Chemodenerv eccrine glands	0.70	0.87	0.30	0.06	1.63	1.06	000
64653	.....	A	Chemodenerv eccrine glands	0.88	0.92	0.38	0.08	1.88	1.34	000
67901	.....	A	Repair eyelid defect	7.39	NA	5.42	0.54	NA	13.35	090
67902	.....	A	Repair eyelid defect	9.35	NA	5.48	0.60	NA	15.43	090
75956	26	A	Xray, endovasc thor ao repr	7.00	2.71	2.71	0.69	10.40	10.40	XXX
75957	26	A	Xray, endovasc thor ao repr	6.00	2.32	2.32	0.59	8.91	8.91	XXX
75958	26	A	Xray, place prox ext thor ao	4.00	1.55	1.55	0.39	5.94	5.94	XXX
75959	26	A	Xray, place dist ext thor ao	3.50	1.36	1.36	0.34	5.20	5.20	XXX
76376	26	A	3d render w/o postprocess	0.20	0.07	0.07	0.02	0.29	0.29	XXX
76377	26	A	3d rendering w/postprocess	0.79	0.27	0.27	0.08	1.14	1.14	XXX
77421	26	A	Stereoscopic x-ray guidance	0.39	0.13	0.13	0.02	0.54	0.54	XXX
77422	.....	A	Neutron beam tx, simple	0.00	1.71	NA	0.13	1.84	NA	XXX
77423	.....	A	Neutron beam tx, complex	0.00	2.26	NA	0.13	2.39	NA	XXX
88333	26	A	Intraop cyto path consult, 1	1.20	0.53	0.53	0.04	1.77	1.77	XXX
88334	26	A	Intraop cyto path consult, 2	0.59	0.26	0.26	0.02	0.87	0.87	XXX
88384	26	C	Eval molecular probes, 11-50	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88385	26	A	Eval molecul probes, 51-250	1.50	0.65	0.65	0.06	2.21	2.21	XXX
88386	26	A	Eval molecul probes, 251-500	1.88	0.82	0.82	0.08	2.78	2.78	XXX
89049	.....	A	Chct for mal hyperthermia	1.40	3.56	0.27	0.06	5.02	1.73	XXX
90760	.....	A	Hydration iv infusion, init	0.17	1.43	1.43	0.07	1.67	1.67	XXX
90761	.....	A	Hydrate iv infusion, add-on	0.09	0.40	0.40	0.04	0.53	0.53	ZZZ
90765	.....	A	Ther/proph/diag iv inf, init	0.21	1.76	1.76	0.07	2.04	2.04	XXX
90766	.....	A	Ther/proph/dg iv inf, add-on	0.18	0.46	0.46	0.04	0.68	0.68	ZZZ
90767	.....	A	Tx/proph/dg addl seq iv inf	0.19	0.89	0.89	0.04	1.12	1.12	ZZZ
90768	.....	A	Ther/diag concurrent inf	0.17	0.44	0.44	0.04	0.65	0.65	ZZZ
90772	.....	A	Ther/proph/diag inj, sc/im	0.17	0.31	0.31	0.01	0.49	0.49	XXX
90773	.....	A	Ther/proph/diag inj, ia	0.17	0.32	0.32	0.02	0.51	0.51	XXX
90774	.....	A	Ther/proph/diag inj, iv push	0.18	1.30	1.30	0.04	1.52	1.52	XXX
90775	.....	A	Ther/proph/diag inj add-on	0.10	0.57	0.57	0.04	0.71	0.71	ZZZ
90779	.....	C	Ther/prop/diag inj/inf proc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
91022	26	A	Duodenal motility study	1.44	0.51	0.51	0.07	2.02	2.02	000
92520	.....	A	Laryngeal function studies	0.75	0.51	0.39	0.03	1.29	1.17	XXX
92626	.....	A	Eval aud rehab status	0.00	0.55	NA	0.06	0.61	NA	XXX
92627	.....	A	Eval aud status rehab add-on	0.00	0.55	NA	0.06	0.61	NA	XXX
92630	.....	I	Aud rehab pre-ling hear loss	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92633	.....	I	Aud rehab postling hear loss	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95251	.....	A	Gluc monitor, cont, phys i&r	0.52	0.19	0.19	0.02	0.73	0.73	XXX
95865	26	A	Muscle test, larynx	1.57	0.77	0.77	0.08	2.42	2.42	XXX
95866	26	A	Muscle test, hemidiaphragm	1.25	0.56	0.56	0.07	1.88	1.88	XXX
95873	26	A	Guide nerv destr, elec stim	0.37	0.16	0.16	0.02	0.55	0.55	ZZZ
95874	26	A	Guide nerv destr, needle emg	0.37	0.17	0.17	0.02	0.56	0.56	ZZZ
96101	.....	A	Psycho testing by psych/phys	1.86	0.65	0.63	0.05	2.56	2.54	XXX
96102	.....	A	Psycho testing by technician	0.50	0.66	0.17	0.01	1.17	0.68	XXX
96103	.....	A	Psycho testing admin by comp	0.51	0.21	0.17	0.02	0.74	0.70	XXX
96116	.....	A	Neurobehavioral status exam	1.86	0.83	0.64	0.18	2.87	2.68	XXX
96118	.....	A	Neuropsych tst by psych/phys	1.86	1.39	0.63	0.18	3.43	2.67	XXX
96119	.....	A	Neuropsych testing by tech	0.55	1.02	0.19	0.18	1.75	0.92	XXX
96120	.....	A	Neuropsych tst admin w/comp	0.51	0.74	0.17	0.02	1.27	0.70	XXX
96401	.....	A	Chemo, anti-neopl, sq/im	0.21	1.53	1.53	0.01	1.75	1.75	XXX
96402	.....	A	Chemo hormon antineopl sq/im	0.19	0.74	0.74	0.01	0.94	0.94	XXX

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ADDENDUM C.—CODES WITH INTERIM RVUS—Continued

CPT[1] HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-Facility Total	Facility Total	Global
96409	.....	A	Chemo, iv push, sngl drug	0.24	2.93	2.93	0.06	3.23	3.23	XXX
96411	.....	A	Chemo, iv push, addl drug	0.20	1.61	1.61	0.06	1.87	1.87	ZZZ
96413	.....	A	Chemo, iv infusion, 1 hr	0.28	4.20	4.20	0.08	4.56	4.56	XXX
96415	.....	A	Chemo, iv infusion, addl hr	0.19	0.77	0.77	0.07	1.03	1.03	ZZZ
96416	.....	A	Chemo prolong infuse w/pump	0.21	4.61	4.61	0.08	4.90	4.90	XXX
96417	.....	A	Chemo iv infus each addl seq	0.21	1.95	1.95	0.07	2.23	2.23	ZZZ
96450	.....	A	Chemotherapy, into CNS	1.53	6.96	1.29	0.09	8.58	2.91	000
96521	.....	A	Refill/maint, portable pump	0.21	3.77	3.77	0.06	4.04	4.04	XXX
96522	.....	A	Refill/maint pump/resvr syst	0.21	2.65	2.65	0.06	2.92	2.92	XXX
96523	.....	T	Irrig drug delivery device	0.04	0.69	0.69	0.01	0.74	0.74	XXX
96542	.....	A	Chemotherapy injection	0.75	4.24	0.66	0.07	5.06	1.48	XXX
97760	.....	A	Orthotic mgmt and training	0.45	0.34	0.20	0.03	0.82	0.68	XXX
97761	.....	A	Prosthetic training	0.45	0.28	0.19	0.02	0.75	0.66	XXX
97762	.....	A	C/o for orthotic/prosth use	0.25	0.42	0.19	0.02	0.69	0.46	XXX
98960	.....	N	Self-mgmt educ & train, 1 pt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
98961	.....	N	Self-mgmt educ/train, 2-4 pt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
98962	.....	N	Self-mgmt educ/train, 5-8 pt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99143	.....	C	Mod cs by same phys, < 5 yrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99144	.....	C	Mod cs by same phys, 5 yrs + ...	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99145	.....	C	Mod cs by same phys add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99148	.....	C	Mod cs diff phys < 5 yrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99149	.....	C	Mod cs diff phys 5 yrs + ...	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99150	.....	C	Mod cs diff phys add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99300	.....	A	Ic, infant pbw 2501-5000 gm	2.40	NA	0.84	2.40	NA	5.64	XXX
99304	.....	A	Nursing facility care, init	1.20	0.49	0.49	0.05	1.74	1.74	XXX
99305	.....	A	Nursing facility care, init	1.61	0.63	0.63	0.07	2.31	2.31	XXX
99306	.....	A	Nursing facility care, init	2.01	0.75	0.75	0.09	2.85	2.85	XXX
99307	.....	A	Nursing fac care, subseq	0.60	0.27	0.27	0.03	0.90	0.90	XXX
99308	.....	A	Nursing fac care, subseq	1.00	0.45	0.45	0.04	1.49	1.49	XXX
99309	.....	A	Nursing fac care, subseq	1.42	0.62	0.62	0.06	2.10	2.10	XXX
99310	.....	A	Nursing fac care, subseq	1.77	0.78	0.78	0.08	2.63	2.63	XXX
99318	.....	A	Annual nursing fac assessmnt	1.20	0.49	0.49	0.05	1.74	1.74	XXX
99324	.....	A	Domicil/r-home visit new pat	1.01	0.49	0.38	0.05	1.55	1.44	XXX
99325	.....	A	Domicil/r-home visit new pat	1.52	0.68	0.55	0.07	2.27	2.14	XXX
99326	.....	A	Domicil/r-home visit new pat	2.27	0.92	0.78	0.10	3.29	3.15	XXX
99327	.....	A	Domicil/r-home visit new pat	3.03	1.17	1.05	0.13	4.33	4.21	XXX
99328	.....	A	Domicil/r-home visit new pat	3.78	1.42	1.31	0.16	5.36	5.25	XXX
99334	.....	A	Domicil/r-home visit est pat	0.76	0.40	0.26	0.04	1.20	1.06	XXX
99335	.....	A	Domicil/r-home visit est pat	1.26	0.58	0.43	0.06	1.90	1.75	XXX
99336	.....	A	Domicil/r-home visit est pat	2.02	0.82	0.66	0.09	2.93	2.77	XXX
99337	.....	A	Domicil/r-home visit est pat	3.03	1.15	0.98	0.13	4.31	4.14	XXX
99339	.....	B	Domicil/r-home care supervis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99340	.....	I	Domicil/r-home care supervis	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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[2] Copyright 2005 American Dental Association. All rights reserved.
[3] +Indicates RVUs are not used for Medicare payment.

ADDENDUM D.—2006 GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY

Carrier	Locality	Locality Name	Work GPCI	PE GPCI	MP GPCI
00510	00	Alabama	1.000	0.846	0.752
00831	01	Alaska	1.017	1.103	1.029
00832	00	Arizona	1.000	0.992	1.069
00520	13	Arkansas	1.000	0.831	0.438
31140	03	Marin/Napa/Solano, CA	1.035	1.340	0.651
31140	05	San Francisco, CA	1.060	1.543	0.651
31140	06	San Mateo, CA	1.073	1.536	0.639
31140	07	Oakland/Berkley, CA	1.054	1.371	0.651
31140	09	Santa Clara, CA	1.083	1.540	0.604
31146	17	Ventura, CA	1.028	1.179	0.744
31146	18	Los Angeles, CA	1.041	1.156	0.954
31146	26	Anaheim/Santa Ana, CA	1.034	1.236	0.954
31140	99	Rest of California*	1.007	1.053	0.733
31146	99	Rest of California*	1.007	1.053	0.733
00824	01	Colorado	1.000	1.014	0.803
00591	00	Connecticut	1.038	1.170	0.900
00903	01	DC + MD/VA Suburbs	1.048	1.250	0.926
00902	01	Delaware	1.012	1.018	0.892
00590	03	Fort Lauderdale, FL	1.000	0.988	1.703
00590	04	Miami, FL	1.000	1.046	2.269
00590	99	Rest of Florida	1.000	0.934	1.272

ADDENDUM D.—2006 GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY—Continued

Carrier	Locality	Locality Name	Work GPCI	PE GPCI	MP GPCI
00511	01	Atlanta, GA	1.010	1.089	0.966
00511	99	Rest of Georgia	1.000	0.872	0.966
00833	01	Hawaii/Guam	1.005	1.111	0.800
05130	00	Idaho	1.000	0.868	0.459
00952	12	East St. Louis, IL	1.000	0.939	1.750
00952	15	Suburban Chicago, IL	1.018	1.115	1.652
00952	16	Chicago, IL	1.025	1.126	1.867
00952	99	Rest of Illinois	1.000	0.872	1.193
00630	00	Indiana	1.000	0.906	0.436
00826	00	Iowa	1.000	0.868	0.589
00650	00	Kansas*	1.000	0.878	0.721
00660	00	Kentucky	1.000	0.854	0.873
00528	01	New Orleans, LA	1.000	0.946	1.197
00528	99	Rest of Louisiana	1.000	0.847	1.058
31142	03	Southern Maine	1.000	1.013	0.637
31142	99	Rest of Maine	1.000	0.886	0.637
00901	01	Baltimore/Surr. Cntys, MD	1.012	1.078	0.947
00901	99	Rest of Maryland	1.000	0.980	0.760
31143	01	Metropolitan Boston	1.030	1.329	0.823
31143	99	Rest of Massachusetts	1.007	1.103	0.823
00953	01	Detroit, MI	1.037	1.054	2.744
00953	99	Rest of Michigan	1.000	0.921	1.518
00954	00	Minnesota	1.000	1.005	0.410
00512	00	Mississippi	1.000	0.839	0.722
00740	02	Metropolitan Kansas City, MO	1.000	0.975	0.946
00523	01	Metropolitan St. Louis, MO	1.000	0.955	0.941
00523	99	Rest of Missouri*	1.000	0.802	0.892
00740	99	Rest of Missouri*	1.000	0.802	0.892
00751	01	Montana	1.000	0.844	0.904
00655	00	Nebraska	1.000	0.875	0.454
00834	00	Nevada	1.003	1.043	1.068
31144	40	New Hampshire	1.000	1.027	0.942
00805	01	Northern NJ	1.058	1.220	0.973
00805	99	Rest of New Jersey	1.043	1.119	0.973
00521	05	New Mexico	1.000	0.887	0.895
00801	99	Rest of New York	1.000	0.917	0.677
00803	01	Manhattan, NY	1.065	1.298	1.504
00803	02	NYC Suburbs/Long I., NY	1.052	1.280	1.785
00803	03	Poughkpsie/N NYC Suburbs, NY	1.014	1.074	1.167
14330	04	Queens, NY	1.032	1.228	1.710
05535	00	North Carolina	1.000	0.920	0.640
00820	01	North Dakota	1.000	0.860	0.602
00883	00	Ohio	1.000	0.933	0.976
00522	00	Oklahoma	1.000	0.854	0.382
00835	01	Portland, OR	1.002	1.057	0.441
00835	99	Rest of Oregon	1.000	0.925	0.441
00865	01	Metropolitan Philadelphia, PA	1.016	1.104	1.386
00865	99	Rest of Pennsylvania	1.000	0.902	0.806
00973	20	Puerto Rico	1.000	0.698	0.261
00524	01	Rhode Island	1.045	0.989	0.909
00880	01	South Carolina	1.000	0.893	0.394
00820	02	South Dakota	1.000	0.876	0.365
05440	35	Tennessee	1.000	0.879	0.631
00900	09	Brazoria, TX	1.020	0.961	1.298
00900	11	Dallas, TX	1.009	1.062	1.061
00900	15	Galveston, TX	1.000	0.952	1.298
00900	18	Houston, TX	1.016	1.014	1.297
00900	20	Beaumont, TX	1.000	0.860	1.298
00900	28	Fort Worth, TX	1.000	0.989	1.061
00900	31	Austin, TX	1.000	1.046	0.986
00900	99	Rest of Texas	1.000	0.865	1.138
00823	09	Utah	1.000	0.937	0.662
31145	50	Vermont	1.000	0.968	0.514
00973	50	Virgin Islands	1.000	1.014	1.003
00904	00	Virginia	1.000	0.940	0.579
00836	02	Seattle (King Cnty), WA	1.014	1.131	0.819
00836	99	Rest of Washington	1.000	0.978	0.819
00884	16	West Virginia	1.000	0.819	1.547
00951	00	Wisconsin	1.000	0.918	0.790
00825	21	Wyoming	1.000	0.853	0.935

For 2005 & 2006, if the work GPCI falls below a 1.0 index, the work GPCI equals 1.0.

* States are served by more than one carrier.

ADDENDUM E.—2006 GAFS

Carrier	Locality	Locality name	2006 GAF
31140	09	Santa Clara, CA	1.265
31140	06	San Mateo, CA	1.259
31140	05	San Francisco, CA	1.256
00803	01	Manhattan, NY	1.184
00803	02	NYC Suburbs/Long I., NY	1.180
31140	07	Oakland/Berkley, CA	1.177
31140	03	Marin/Napa/Solano, CA	1.154
31143	01	Metropolitan Boston	1.153
14330	04	Queens, NY	1.144
00903	01	DC + MD/VA Suburbs	1.132
00805	01	Northern NJ	1.126
31146	26	Anaheim/Santa Ana, CA	1.119
00953	01	Detroit, MI	1.111
00952	16	Chicago, IL	1.102
00591	00	Connecticut	1.091
31146	18	Los Angeles, CA	1.088
00952	15	Suburban Chicago, IL	1.085
31146	17	Ventura, CA	1.083
00805	99	Rest of New Jersey	1.074
00865	01	Metropolitan Philadelphia, PA	1.069
00590	04	Miami, FL	1.069
00836	02	Seattle (King Cnty), WA	1.058
00831	01	Alaska	1.055
00803	03	Poughkpsie/N NYC Suburbs, NY	1.046
00833	01	Hawaii/Guam	1.044
00511	01	Atlanta, GA	1.043
31143	99	Rest of Massachusetts	1.042
00901	01	Baltimore/Surr. Cntys, MD	1.039
00900	11	Dallas, TX	1.034
00900	18	Houston, TX	1.026
00834	00	Nevada	1.023
00590	03	Fort Lauderdale, FL	1.022
00900	31	Austin, TX	1.020
31146	99	Rest of California*	1.017
31140	99	Rest of California*	1.017
31144	40	New Hampshire	1.010
00902	01	Delaware	1.010
00973	50	Virgin Islands	1.007
00900	09	Brazoria, TX	1.005
00835	01	Portland, OR	1.005
00952	12	East St. Louis, IL	1.003
00832	00	Arizona	0.999
00824	01	Colorado	0.999
00900	28	Fort Worth, TX	0.998
31142	03	Southern Maine	0.992
00900	15	Galveston, TX	0.991
00740	02	Metropolitan Kansas City, MO	0.987
00953	99	Rest of Michigan	0.986
00836	99	Rest of Washington	0.984
00528	01	New Orleans, LA	0.984
00901	99	Rest of Maryland	0.982
00590	99	Rest of Florida	0.982
00954	00	Minnesota	0.980
00523	01	Metropolitan St. Louis, MO	0.978
00883	00	Ohio	0.970
31145	50	Vermont	0.968
00823	09	Utah	0.960
00904	00	Virginia	0.958
00951	00	Wisconsin	0.956
00952	99	Rest of Illinois	0.952
00801	99	Rest of New York	0.952
05535	00	North Carolina	0.951
00900	20	Beaumont, TX	0.951
00865	99	Rest of Pennsylvania	0.950
00900	99	Rest of Texas	0.947
00521	05	New Mexico	0.947
00835	99	Rest of Oregon	0.946
00511	99	Rest of Georgia	0.943
00740	99	Rest of Missouri*	0.910

ADDENDUM E.—2006 GAFS—Continued

Carrier	Locality	Locality name	2006 GAF
00884	16	West Virginia	0.942
00630	00	Indiana	0.937
31142	99	Rest of Maine	0.936
00650	00	Kansas*	0.936
00528	99	Rest of Louisiana	0.936
00825	21	Wyoming	0.934
05440	35	Tennessee	0.933
00660	00	Kentucky	0.932
00880	01	South Carolina	0.930
00870	01	Rhode Island	0.930
00751	01	Montana	0.928
00826	00	Iowa	0.927
00655	00	Nebraska	0.925
00820	01	North Dakota	0.924
00510	00	Alabama	0.923
05130	00	Idaho	0.922
00820	02	South Dakota	0.922
00512	00	Mississippi	0.919
00522	00	Oklahoma	0.913
00740	99	Rest of Missouri*	0.910
00523	99	Rest of Missouri*	0.910
00520	13	Arkansas	0.905
00973	20	Puerto Rico	0.840

* States are served by more than one carrier.

ADDENDUM F.—REVISED SINGLE DRUG CATEGORY LIST

HCPCS	Long description	Recalculated weights
J0150	INJECTION, ADENOSINE FOR THERAPEUTIC USE, 6 MG	0.00069828
J0152	INJECTION, ADENOSINE FOR DIAGNOSTIC USE, 30 MG	0.00458348
J0170	INJECTION, ADRENALIN, EPINEPHRINE, 1 ML AMPULE	0.00007878
J0207	INJECTION, AMIFOSTINE, 500 MG	0.00016059
J0215	INJECTION, ALEFACEPT, 0.5 MG	0.00083178
J0280	INJECTION, AMINOPHYLLIN, 250 MG	0.00081886
J0290	INJECTION, AMPICILLIN SODIUM, 500 MG	0.00012626
J0475	INJECTION, BACLOFEN, 10 MG	0.00024582
J0540	INJECTION, PENICILLIN G BENZATHINE AND PENICILLIN G PROCAINE, 1,200,000 UNITS	0.00007191
J0550	INJECTION, PENICILLIN G BENZATHINE AND PENICILLIN G PROCAINE, 2,400,000 UNITS	0.00001826
J0570	INJECTION, PENICILLIN G BENZATHINE, 1,200,000 UNITS	0.00004593
J0585	BOTULINUM TOXIN TYPE A, PER UNIT	0.03734001
J0587	BOTULINUM TOXIN TYPE B, PER 100 UNITS	0.00150333
J0600	INJECTION, EDETATE CALCIUM DISODIUM, 1000 MG	0.00004448
J0637	INJECTION, CASPOFUNGIN ACETATE, 5 MG	0.00008462
J0640	INJECTION, LEUCOVORIN CALCIUM, PER 50 MG	0.01061886
J0670	INJECTION, MEPIVACAINE HYDROCHLORIDE, PER 10 ML	0.00038303
J0690	INJECTION, CEFAZOLIN SODIUM, 500 MG	0.00042306
J0692	INJECTION, CEFEPIME HYDROCHLORIDE, 500 MG	0.00024785
J0696	INJECTION, CEFTRIAXONE SODIUM, PER 250 MG	0.00667188
J0698	INJECTION, CEFOTAXIME SODIUM, PER GM	0.00014842
J0702	INJECTION, BETAMETHASONE ACETATE & BETAMETHASONE SODIUM PHOSPHATE, PER 3 MG	0.00287002
J0704	INJECTION, BETAMETHASONE SODIUM PHOSPHATE, PER 4 MG	0.00056918
J0735	INJECTION, CLONIDINE HYDROCHLORIDE, 1 MG	0.00034065
J0800	INJECTION, CORTICOTROPIN, 40 UNITS	0.00363050
J0895	INJECTION, DEFEROXAMINE MESYLATE, 500 MG	0.00024388
J1000	INJECTION, DEPO-ESTRADIOL CYPIONATE, 5 MG	0.00020962
J1020	INJECTION, METHYLPREDNISOLONE ACETATE, 20 MG	0.00127016
J1030	INJECTION, METHYLPREDNISOLONE ACETATE, 40 MG	0.00591680
J1040	INJECTION, METHYLPREDNISOLONE ACETATE, 80 MG	0.00526505
J1051	INJECTION, MEDROXYPROGESTERONE ACETATE, 50 MG	0.00006510
J1094	INJECTION, DEXAMETHASONE ACETATE, 1 MG	0.00350405
J1100	INJECTION, DEXAMETHASONE SODIUM PHOSPHATE, 1MG	0.05478551
J1190	INJECTION, DEXRAZOXANE HYDROCHLORIDE, PER 250 MG	0.00002438
J1200	INJECTION, DIPHENHYDRAMINE HCL, 50 MG	0.00215958
J1212	INJECTION, DMSO, DIMETHYL SULFOXIDE, 50%, 50 ML	0.00008455
J1245	INJECTION, DIPYRIDAMOLE, PER 10 MG	0.00382235
J1250	INJECTION, DOBUTAMINE HYDROCHLORIDE, PER 250 MG	0.00053051
J1260	INJECTION, DOLASETRON MESYLATE, 10 MG	0.01732829
J1335	INJECTION, ERTAPENEM SODIUM, 500 MG	0.00013230

ADDENDUM F.—REVISED SINGLE DRUG CATEGORY LIST—Continued

HCPCS	Long description	Recalculated weights
J1440	INJECTION, FILGRASTIM (G-CSF), 300 MCG	0.00193096
J1441	INJECTION, FILGRASTIM (G-CSF), 480 MCG	0.00406386
J1450	INJECTION FLUCONAZOLE, 200 MG	0.00001605
J1580	INJECTION, GARAMYCIN, GENTAMICIN, 80 MG	0.00039839
J1600	INJECTION, GOLD SODIUM THIOMALATE, 50 MG	0.00005600
J1626	INJECTION, GRANISETRON HYDROCHLORIDE, 100 MCG	0.01480082
J1631	INJECTION, HALOPERIDOL DECANOATE, PER 50 MG	0.00020651
J1642	INJECTION, HEPARIN SODIUM, (HEPARIN LOCK FLUSH), PER 10 UNITS	0.06406943
J1644	INJECTION, HEPARIN SODIUM, PER 1000 UNITS	0.00353690
J1645	INJECTION, DALTEPARIN SODIUM, PER 2500 IU	0.00011497
J1650	INJECTION, ENOXAPARIN SODIUM, 10 MG	0.00135285
J1655	INJECTION, TINZAPARIN SODIUM, 1000 IU	0.00047054
J1720	INJECTION, HYDROCORTISONE SODIUM SUCCINATE, 100 MG	0.00013295
J1745	INJECTION INFLIXIMAB, 10 MG	0.02755927
J1750	INJECTION, IRON DEXTRAN, 50 MG	0.00245914
J1756	INJECTION, IRON SUCROSE, 1 MG	0.01024469
J1885	INJECTION, KETOROLAC TROMETHAMINE, PER 15 MG	0.00329270
J1940	INJECTION, FUROSEMIDE, 20 MG	0.00065208
J1956	INJECTION, LEVOFLOXACIN, 250 MG	0.00008608
J2001	INJECTION, LIDOCAINE HCL FOR INTRAVENOUS INFUSION, 10 MG	0.00077337
J2010	INJECTION, LINCOMYCIN HCL, 300 MG	0.00062307
J2150	INJECTION, MANNITOL, 25% IN 50 ML	0.00029139
J2260	INJECTION, MILRINONE LACTATE, 5 MG	0.00004947
J2300	INJECTION, NALBUPHINE HYDROCHLORIDE, PER 10 MG	0.00026276
J2325	INJECTION, NESIRITIDE, 0.1 MG	0.00027338
J2353	INJECTION, OCTREOTIDE, DEPOT FORM FOR INTRAMUSCULAR INJECTION, 1 MG	0.00194628
J2354	INJECTION, OCTREOTIDE, NON-DEPOT SUBCUTANEOUS OR INTRAVENOUS INJECTION, 25 MCG	0.00008391
J2405	INJECTION, ONDANSETRON HYDROCHLORIDE, PER 1 MG	0.01369661
J2430	INJECTION, PAMIDRONATE DISODIUM, PER 30 MG	0.00156404
J2505	INJECTION, PEGFILGRASTIM, 6 MG	0.00064954
J2550	INJECTION, PROMETHAZINE HCL, 50 MG	0.00068512
J2680	INJECTION, FLUPHENAZINE DECANOATE, 25 MG	0.00015076
J2765	INJECTION, METOCLOPRAMIDE HCL, 10 MG	0.00011107
J2780	INJECTION, RANITIDINE HYDROCHLORIDE, 25 MG	0.00088333
J2820	INJECTION, SARGRAMOSTIM (GM-CSF), 50 MCG	0.00217374
J2912	INJECTION, SODIUM CHLORIDE, 0.9%, PER 2 ML	0.00678337
J2916	INJECTION, SODIUM FERRIC GLUCONATE COMPLEX IN SUCROSE INJECTION, 12.5 MG	0.00060984
J2920	INJECTION, METHYLPREDNISOLONE SODIUM SUCCINATE, 40 MG	0.00031153
J2930	INJECTION, METHYLPREDNISOLONE SODIUM SUCCINATE, 125 MG	0.00077009
J2997	INJECTION, ALTEPLASE RECOMBINANT, 1 MG	0.00012209
J3260	INJECTION, TOBRAMYCIN SULFATE, 80 MG	0.00018247
J3301	INJECTION, TRIAMCINOLONE ACETONIDE, PER 10MG	0.02161210
J3302	INJECTION, TRIAMCINOLONE DIACETATE, PER 5MG	0.00172788
J3303	INJECTION, TRIAMCINOLONE HEXACETONIDE, PER 5MG	0.00094370
J3315	INJECTION, TRIPTORELIN PAMOATE, 3.75 MG	0.00000712
J3370	INJECTION, VANCOMYCIN HCL, 500 MG	0.00083980
J3396	INJECTION, VERTEPORFIN, 0.1 MG	0.05425250
J3410	INJECTION, HYDROXYZINE HCL, 25 MG	0.00040904
J3420	INJECTION, VITAMIN B-12 CYANOCOBALAMIN, UP TO 1000 MCG	0.01200091
J3475	INJECTION, MAGNESIUM SULFATE, PER 500 MG	0.00108238
J3480	INJECTION, POTASSIUM CHLORIDE, PER 2 MEQ	0.00215178
J3487	INJECTION, ZOLEDRONIC ACID, 1 MG	0.00335651
J7030	INFUSION, NORMAL SALINE SOLUTION , 1000 CC	0.00102582
J7040	INFUSION, NORMAL SALINE SOLUTION, STERILE (500 ML=1 UNIT)	0.00242568
J7042	5% DEXTROSE/NORMAL SALINE (500 ML = 1 UNIT)	0.00049750
J7050	INFUSION, NORMAL SALINE SOLUTION , 250 CC	0.00990901
J7060	5% DEXTROSE/WATER (500 ML = 1 UNIT)	0.00102607
J7070	INFUSION, D5W, 1000 CC	0.00015855
J7120	RINGERS LACTATE INFUSION, 1000 CC	0.00016938
J7318	HYALURONAN (SODIUM HYALURONATE) OR DERIVATIVE, INTRA-ARTICULAR INJECTION, 1 MG	0.00340613
J9000	DOXORUBICIN HCL, 10 MG	0.00235266
J9001	DOXORUBICIN HYDROCHLORIDE, ALL LIPID FORMULATIONS, 10 MG	0.00032456
J9031	BCG (INTRAVESICAL) PER INSTILLATION	0.00049146
J9040	BLEOMYCIN SULFATE, 15 UNITS	0.00003718
J9045	CARBOPLATIN, 50 MG	0.00568694
J9050	CARMUSTINE, 100 MG	0.00000887
J9060	CISPLATIN, POWDER OR S0LUTION, PER 10 MG	0.00095159
J9062	CISPLATIN, 50 MG	0.00025368
J9065	INJECTION, CLADRIBINE, PER 1 MG	0.00008122
J9070	CYCLOPHOSPHAMIDE, 100 MG	0.00062537
J9080	CYCLOPHOSPHAMIDE, 200 MG	0.00004956

ADDENDUM F.—REVISED SINGLE DRUG CATEGORY LIST—Continued

HCPCS	Long description	Recalculated weights
J9090	CYCLOPHOSPHAMIDE, 500 MG	0.00008105
J9091	CYCLOPHOSPHAMIDE, 1.0 GRAM	0.00005036
J9092	CYCLOPHOSPHAMIDE, 2.0 GRAM	0.00000528
J9093	CYCLOPHOSPHAMIDE, LYOPHILIZED, 100 MG	0.00092452
J9094	CYCLOPHOSPHAMIDE, LYOPHILIZED, 200 MG	0.00009167
J9095	CYCLOPHOSPHAMIDE, LYOPHILIZED, 500 MG	0.00017653
J9096	CYCLOPHOSPHAMIDE, LYOPHILIZED, 1.0 GRAM	0.00013943
J9097	CYCLOPHOSPHAMIDE, LYOPHILIZED, 2.0 GRAM	0.00001356
J9098	CYTARABINE LIPOSOME, 10 MG	0.00000815
J9100	CYTARABINE, 100 MG	0.00012978
J9110	CYTARABINE, 500 MG	0.00002071
J9130	DACARBAZINE, 100 MG	0.00009406
J9140	DACARBAZINE, 200 MG	0.00007007
J9150	DAUNORUBICIN, 10 MG	0.00000488
J9170	DOCETAXEL, 20 MG	0.00256588
J9178	INJECTION, EPIRUBICIN HCL, 2 MG	0.00121617
J9181	ETOPOSIDE, 10 MG	0.00230896
J9182	ETOPOSIDE, 100 MG	0.00052981
J9185	FLUDARABINE PHOSPHATE, 50 MG	0.00030572
J9190	FLUOROURACIL, 500 MG	0.00395219
J9200	FLOXURIDINE, 500 MG	0.00000408
J9201	GEMCITABINE HCL, 200 MG	0.00494962
J9202	GOSERELIN ACETATE IMPLANT, PER 3.6 MG	0.00287887
J9206	IRINOTECAN, 20 MG	0.00318310
J9208	IFOSFAMIDE, 1 GM	0.00007873
J9209	MESNA, 200 MG	0.00036778
J9211	IDARUBICIN HYDROCHLORIDE, 5 MG	0.00000318
J9213	INTERFERON, ALFA-2A, RECOMBINANT, 3 MILLION UNITS	0.00008062
J9214	INTERFERON, ALFA-2B, RECOMBINANT, 1 MILLION UNITS	0.00673538
J9219	LEUPROLIDE ACETATE IMPLANT, 65 MG	0.00006510
J9245	INJECTION, MELPHALAN HYDROCHLORIDE, 50 MG	0.00000158
J9250	METHOTREXATE SODIUM, 5 MG	0.00186241
J9260	METHOTREXATE SODIUM, 50 MG	0.00051323
J9263	INJECTION, OXALIPLATIN, 0.5 MG	0.07300568
J9265	PACLITAXEL, 30 MG	0.00555323
J9268	PENTOSTATIN, PER 10 MG	0.00000643
J9280	MITOMYCIN, 5 MG	0.00004067
J9290	MITOMYCIN, 20 MG	0.00003473
J9291	MITOMYCIN, 40 MG	0.00006128
J9293	INJECTION, MITOXANTRONE HYDROCHLORIDE, PER 5 MG	0.00025058
J9310	RITUXIMAB, 100 MG	0.00408558
J9320	STREPTOZOCIN, 1 GM	0.00000671
J9340	THIOTEPA, 15 MG	0.00002446
J9350	TOPOTECAN, 4 MG	0.00018223
J9355	TRASTUZUMAB, 10 MG	0.00542012
J9360	VINBLASTINE SULFATE, 1 MG	0.00035725
J9370	VINCRISTINE SULFATE, 1 MG	0.00019702
J9375	VINCRISTINE SULFATE, 2 MG	0.00011487
J9390	VINORELBINE TARTRATE, PER 10 MG	0.00110762
J9395	INJECTION, FULVESTRANT, 25 MG	0.00126358
J9600	PORFIMER SODIUM, 75 MG	0.00000030
J0885	INJECTION, EPOETIN ALPHA, (FOR NON ESRD USE), PER 1000 UNITS	0.25074794
J0881	INJECTION, DARBEPOETIN ALFA, 1 MCG (NON-ESRD USE)	0.15914222
Q3025	INJECTION, INTERFERON BETA-1A, 11 MCG FOR INTRAMUSCULAR USE	0.00078070

ADDENDUM G.—REVISED NEW DRUGS FOR CAP BIDDING FOR 2006

[Effective January 1, 2006]

HCPCS	Long description
J0128	Abarelix injection.
J0180	Agalsidase beta injection.
J0278	Amikacin.
J0878	Daptomycin injection.
J1751	Iron Dextran 165.
J1752	Iron Dextran 267.
J1931	Laronidase injection.
J2357	Omalizumab injection.

ADDENDUM G.—REVISED NEW DRUGS FOR CAP BIDDING FOR 2006—Continued

[Effective January 1, 2006]

HCPCS	Long description
J2469	Palonosetron HCl.
J2503	Pegaptanib.
J2794	Risperidone, long acting.
J9035	Bevacizumab injection.
J9041	Bortezomib injection.
J9055	Cetuximab injection.
J9225	Histrelin implant.

ADDENDUM G.—REVISED NEW DRUGS FOR CAP BIDDING FOR 2006—Continued

[Effective January 1, 2006]

HCPCS	Long description
J9264	Paclitaxel protein bound particles.
J9305	Pemetrexed injection.

ADDENDUM H.—LIST OF CPT [1]/ HCPCS CODES USED TO DESCRIBE CERTAIN DESIGNATED HEALTH SERVICE CATEGORIES [2] UNDER SECTION 1877 OF THE SOCIAL SECURITY ACT

[Effective Date: All codes are effective January 1, 2006, except those followed by an asterisk. Codes followed by an asterisk will become effective on January 1, 2007.]

CLINICAL LABORATORY SERVICES

Include CPT codes for all clinical laboratory services in the 80000 series, except EXCLUDE CPT codes for the following blood component collection services:

86890	Autologous blood process
86891	Autologous blood, op salvage
86927	Plasma, fresh frozen
86930	Frozen blood prep
86931	Frozen blood thaw
86932	Frozen blood freeze/thaw
86945	Blood product/irradiation
86950	Leukacyte transfusion
86965	Pooling blood platelets
86985	Split blood or products

Include the following CPT and HCPCS level 2 codes for other clinical laboratory services:

0026T	Measure remnant lipoproteins
0030T	Antiprothrombin antibody
0041T	Detect ur infect agnt w/cpas
0043T	Co expired gas analysis
0058T	Cryopreservation, ovary tiss
0059T	Cryopreservation, oocyte
0064T	Spectroscop eval expired gas
0085T	Breath test heart reject
0087T	Sperm eval hyaluronan
0103T	Holotranscobalamin
0104T	At rest cardio gas rebreathe
0111T	RBC membranes fatty acids
0140T	Exhaled breath condensate ph
36415	Routine venipuncture
78267	Breath test attain/anal c-14
78268	Breath test analysis c-14
G0027	Semen analysis
G0103	Psa, total screening
G0107	CA screen; fecal blood test
G0123	Screen cerv/vag thin layer
G0124	Screen c/v thin layer by MD
G0141	Scr c/v cyto,autosys and md
G0143	Scr c/v cyto,thinlayer,rescr
G0144	Scr c/v cyto,thinlayer,rescr
G0145	Scr c/v cyto,thinlayer,rescr
G0147	Scr c/v cyto, automated sys
G0148	Scr c/v cyto, autosys, rescr
G0306	CBC/diffwbc w/o platelet
G0307	CBC without platelet
G0328	Fecal blood scrn immunoassay
P2028	Cephalin floculation test
P2029	Congo red blood test
P2033	Blood thymol turbidity
P2038	Blood mucoprotein
P3000	Screen pap by tech w md supv
P3001	Screening pap smear by phys
P9612	Catheterize for urine spec
P9615	Urine specimen collect mult
Q0111	Wet mounts/ w preparations
Q0112	Potassium hydroxide preps
Q0113	Pinworm examinations
Q0114	Fern test
Q0115	Post-coital mucous exam

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH-LANGUAGE PATHOLOGY

Include the following CPT and HCPCS codes for the physical therapy/occupational therapy/speech-language pathology services:

0019T	Extracorp shock wv tx,ms nos
0029T	Magnetic tx for incontinence
64550	Apply neurostimulator
90901	Biofeedback train, any meth
90911	Biofeedback peri/uro/rectal
92506	Speech/hearing evaluation
92507	Speech/hearing therapy
92508	Speech/hearing therapy
92526	Oral function therapy
92597	Oral speech device eval
92607	Ex for speech device rx, 1hr
92608	Ex for speech device rx addl
92609	Use of speech device service
92610	Evaluate swallowing function
92611	Motion fluoroscopy/swallow
92612	Endoscopy swallow tst (fees)
92614	Laryngoscopic sensory test
92616	Fees w/laryngeal sense test
93797	Cardiac rehab
93798	Cardiac rehab/monitor
94667	Chest wall manipulation
94668	Chest wall manipulation
95831	Limb muscle testing, manual
95832	Hand muscle testing, manual
95833	Body muscle testing, manual
95834	Body muscle testing, manual
95851	Range of motion measurements
95852	Range of motion measurements
96000	Motion analysis, video/3d
96001	Motion test w/ft press meas
96002	Dynamic surface emg
96003	Dynamic fine wire emg
96105	Assessment of aphasia
96110	Developmental test, lim
96111	Developmental test, extend
97001	Pt evaluation
97002	Pt re-evaluation
97003	Ot evaluation
97004	Ot re-evaluation
97010	Hot or cold packs therapy
97012	Mechanical traction therapy
97016	Vasopneumatic device therapy
97018	Paraffin bath therapy
97022	Whirlpool therapy
97024	Diathermy eg, microwave
97026	Infrared therapy
97028	Ultraviolet therapy
97032	Electrical stimulation
97033	Electric current therapy
97034	Contrast bath therapy
97035	Ultrasound therapy
97036	Hydrotherapy
97039	Physical therapy treatment
97110	Therapeutic exercises
97112	Neuromuscular reeducation
97113	Aquatic therapy/exercises
97116	Gait training therapy
97124	Massage therapy
97139	Physical medicine procedure
97140	Manual therapy
97150	Group therapeutic procedures
97530	Therapeutic activities
97532	Cognitive skills development
97533	Sensory integration
97535	Self care mngment training
97537	Community/work reintegration
97542	Wheelchair mngment training
97545	Work hardening
97546	Work hardening add-on
97597	Active wound care/20cm or <
97598	Active wound care > 20cm
97602	Wound(s) care nonselective
97605	Neg press wound tx, < 50 cm
97606	Neg press wound tx, > 50 cm
97750	Physical performance test
97755	Assistive technology assess
97760	Orthotic mgmt and training
97761	Prosthetic training
97762	C/O for orthotic/prosth use
97799	Physical medicine procedure
G0281	Elec stim unattend for press
G0283	Elec stim other than wound
G0329	Electromagntic tx for ulcers

RADIOLOGY AND CERTAIN OTHER IMAGING SERVICES

Include the following CPT and HCPCS codes:

0028T	Dexa body composition study
0042T	Ct perfusion w/contrast, cbf
0067T	Ct colonography;dx
51798	Us urine capacity measure
70100	X-ray exam of jaw
70110	X-ray exam of jaw
70120	X-ray exam of mastoids
70130	X-ray exam of mastoids
70134	X-ray exam of middle ear
70140	X-ray exam of facial bones
70150	X-ray exam of facial bones
70160	X-ray exam of nasal bones
70190	X-ray exam of eye sockets
70200	X-ray exam of eye sockets
70210	X-ray exam of sinuses
70220	X-ray exam of sinuses
70240	X-ray exam, pituitary saddle
70250	X-ray exam of skull
70260	X-ray exam of skull
70300	X-ray exam of teeth
70310	X-ray exam of teeth
70320	Full mouth x-ray of teeth
70328	X-ray exam of jaw joint
70330	X-ray exam of jaw joints
70336	Magnetic image, jaw joint
70350	X-ray head for orthodontia
70355	Panoramic x-ray of jaws
70360	X-ray exam of neck
70370	Throat x-ray & fluoroscopy
70371	Speech evaluation, complex
70380	X-ray exam of salivary gland
70450	Ct head/brain w/o dye
70460	Ct head/brain w/dye
70470	Ct head/brain w/o & w/dye
70480	Ct orbit/ear/fossa w/o dye
70481	Ct orbit/ear/fossa w/dye
70482	Ct orbit/ear/fossa w/o&w/dye
70486	Ct maxillofacial w/o dye
70487	Ct maxillofacial w/dye
70488	Ct maxillofacial w/o & w/dye
70490	Ct soft tissue neck w/o dye
70491	Ct soft tissue neck w/dye
70492	Ct sft tsue nck w/o & w/dye
70496	Ct angiography, head
70498	Ct angiography, neck
70540	Mri orbit/face/neck w/o dye
70542	Mri orbit/face/neck w/dye
70543	Mri orbt/fac/nck w/o & w/dye
70544	Mr angiography head w/o dye
70545	Mr angiography head w/dye
70546	Mr angiograph head w/o&w/dye
70547	Mr angiography neck w/o dye
70548	Mr angiography neck w/dye
70549	Mr angiograph neck w/o&w/dye
70551	Mri brain w/o dye
70552	Mri brain w/dye
70553	Mri brain w/o & w/dye
71010	Chest x-ray
71015	Chest x-ray
71020	Chest x-ray
71021	Chest x-ray
71022	Chest x-ray

ADDENDUM H.—LIST OF CPT [1]/ HCPCS CODES USED TO DESCRIBE CERTAIN DESIGNATED HEALTH SERVICE CATEGORIES [2] UNDER SECTION 1877 OF THE SOCIAL SECURITY ACT—Continued

[Effective Date: All codes are effective January 1, 2006, except those followed by an asterisk. Codes followed by an asterisk will become effective on January 1, 2007.]

71023	Chest x-ray and fluoroscopy
71030	Chest x-ray
71034	Chest x-ray and fluoroscopy
71035	Chest x-ray
71100	X-ray exam of ribs
71101	X-ray exam of ribs/chest
71110	X-ray exam of ribs
71111	X-ray exam of ribs/chest
71120	X-ray exam of breastbone
71130	X-ray exam of breastbone
71250	Ct thorax w/o dye
71260	Ct thorax w/dye
71270	Ct thorax w/o & w/dye
71275	Ct angiography, chest
71550	Mri chest w/o dye
71551	Mri chest w/dye
71552	Mri chest w/o & w/dye
71555	Mri angio chest w or w/o dye
72010	X-ray exam of spine
72020	X-ray exam of spine
72040	X-ray exam of neck spine
72050	X-ray exam of neck spine
72052	X-ray exam of neck spine
72069	X-ray exam of trunk spine
72070	X-ray exam of thoracic spine
72072	X-ray exam of thoracic spine
72074	X-ray exam of thoracic spine
72080	X-ray exam of trunk spine
72090	X-ray exam of trunk spine
72100	X-ray exam of lower spine
72110	X-ray exam of lower spine
72114	X-ray exam of lower spine
72120	X-ray exam of lower spine
72125	Ct neck spine w/o dye
72126	Ct neck spine w/dye
72127	Ct neck spine w/o & w/dye
72128	Ct chest spine w/o dye
72129	Ct chest spine w/dye
72130	Ct chest spine w/o & w/dye
72131	Ct lumbar spine w/o dye
72132	Ct lumbar spine w/dye
72133	Ct lumbar spine w/o & w/dye
72141	Mri neck spine w/o dye
72142	Mri neck spine w/dye
72146	Mri chest spine w/o dye
72147	Mri chest spine w/dye
72148	Mri lumbar spine w/o dye
72149	Mri lumbar spine w/dye
72156	Mri neck spine w/o & w/dye
72157	Mri chest spine w/o & w/dye
72158	Mri lumbar spine w/o & w/dye
72170	X-ray exam of pelvis
72190	X-ray exam of pelvis
72191	Ct angiograph pelv w/o&w/dye
72192	Ct pelvis w/o dye
72193	Ct pelvis w/dye
72194	Ct pelvis w/o & w/dye
72195	Mri pelvis w/o dye
72196	Mri pelvis w/dye
72197	Mri pelvis w/o & w/dye
72198	Mr angio pelvis w/o & w/dye
72200	X-ray exam sacroiliac joints
72202	X-ray exam sacroiliac joints
72220	X-ray exam of tailbone
73000	X-ray exam of collar bone
73010	X-ray exam of shoulder blade
73020	X-ray exam of shoulder
73030	X-ray exam of shoulder
73050	X-ray exam of shoulders
73060	X-ray exam of humerus
73070	X-ray exam of elbow
73080	X-ray exam of elbow
73090	X-ray exam of forearm
73092	X-ray exam of arm, infant
73100	X-ray exam of wrist
73110	X-ray exam of wrist
73120	X-ray exam of hand
73130	X-ray exam of hand
73140	X-ray exam of finger(s)
73200	Ct upper extremity w/o dye
73201	Ct upper extremity w/dye
73202	Ct uppr extremity w/o&w/dye
73206	Ct angio upr extrm w/o&w/dye
73218	Mri upper extremity w/o dye
73219	Mri upper extremity w/dye
73220	Mri uppr extremity w/o&w/dye
73221	Mri joint upr extrem w/o dye
73222	Mri joint upr extrem w/dye
73223	Mri joint upr extr w/o&w/dye
73500	X-ray exam of hip
73510	X-ray exam of hip
73520	X-ray exam of hips
73540	X-ray exam of pelvis & hips
73550	X-ray exam of thigh
73560	X-ray exam of knee, 1 or 2
73562	X-ray exam of knee, 3
73564	X-ray exam, knee, 4 or more
73565	X-ray exam of knees
73590	X-ray exam of lower leg
73592	X-ray exam of leg, infant
73600	X-ray exam of ankle
73610	X-ray exam of ankle
73620	X-ray exam of foot
73630	X-ray exam of foot
73650	X-ray exam of heel
73660	X-ray exam of toe(s)
73700	Ct lower extremity w/o dye
73701	Ct lower extremity w/dye
73702	Ct lwr extremity w/o&w/dye
73706	Ct angio lwr extr w/o&w/dye
73718	Mri lower extremity w/o dye
73719	Mri lower extremity w/dye
73720	Mri lwr extremity w/o&w/dye
73721	Mri jnt of lwr extre w/o dye
73722	Mri joint of lwr extr w/dye
73723	Mri joint lwr extr w/o&w/dye
73725	Mr ang lwr ext w or w/o dye
74000	X-ray exam of abdomen
74010	X-ray exam of abdomen
74020	X-ray exam of abdomen
74022	X-ray exam series, abdomen
74150	Ct abdomen w/o dye
74160	Ct abdomen w/dye
74170	Ct abdomen w/o & w/dye
74175	Ct angio abdom w/o & w/dye
74181	Mri abdomen w/o dye
74182	Mri abdomen w/dye
74183	Mri abdomen w/o & w/dye
74185	Mri angio, abdom w orw/o dye
74210	Contrst x-ray exam of throat
74220	Contrast x-ray, esophagus
74230	Cine/vid x-ray, throat/esoph
74240	X-ray exam, upper gi tract
74241	X-ray exam, upper gi tract
74245	X-ray exam, upper gi tract
74246	Contrst x-ray uppr gi tract
74247	Contrst x-ray uppr gi tract
74249	Contrst x-ray uppr gi tract
74250	X-ray exam of small bowel
74290	Contrast x-ray, gallbladder
74291	Contrast x-rays, gallbladder
74710	X-ray measurement of pelvis
75552	Heart mri for morph w/o dye
75553	Heart mri for morph w/dye
75554	Cardiac MRI/function
75555	Cardiac MRI/limited study
75635	Ct angio abdominal arteries
76000	Fluoroscope examination
76006	X-ray stress view
76010	X-ray, nose to rectum
76020	X-rays for bone age
76040	X-rays, bone evaluation
76061	X-rays, bone survey
76062	X-rays, bone survey
76065	X-rays, bone evaluation
76066	Joint survey, single view
76070	Ct bone density, axial
76071	Ct bone density, peripheral
76075	Dxa bone density, axial
76076	Dxa bone density/peripheral
76077	Dxa bone density/v-fracture
76078	Radiographic absorptiometry
76082	Computer mammogram add-on
76083	Computer mammogram add-on
76090	Mammogram, one breast
76091	Mammogram, both breasts
76092	Mammogram, screening
76093	Magnetic image, breast
76094	Magnetic image, both breasts
76100	X-ray exam of body section
76101	Complex body section x-ray
76102	Complex body section x-rays
76120	Cine/video x-rays
76125	Cine/video x-rays add-on
76150	X-ray exam, dry process
76370	Ct scan for therapy guide
76376	3d render w/o postprocess
76377	3d rendering w/postprocess
76380	CAT scan follow-up study
76400	Magnetic image, bone marrow
76499	Radiographic procedure
76506	Echo exam of head
76510	Ophth us, b & quant a
76511	Ophth us, quant a only
76512	Ophth us, b w/non-quant a
76513	Echo exam of eye, water bath
76514	Echo exam of eye, thickness
76516	Echo exam of eye
76519	Echo exam of eye
76536	Us exam of head and neck
76604	Us exam, chest, b-scan
76645	Us exam, breast(s)
76700	Us exam, abdom, complete
76705	Echo exam of abdomen
76770	Us exam abdo back wall, comp
76775	Us exam abdo back wall, lim
76778	Us exam kidney transplant
76800	Us exam, spinal canal
76801	Ob us < 14 wks, single fetus
76802	Ob us < 14 wks, add'l fetus
76805	Ob us >/= 14 wks, sngl fetus
76810	Ob us >/= 14 wks, addl fetus
76811	Ob us, detailed, sngl fetus
76812	Ob us, detailed, addl fetus
76815	Ob us, limited, fetus(s)
76816	Ob us, follow-up, per fetus
76818	Fetal biophys profile w/nst
76819	Fetal biophys profil w/o nst
76820	Umbilical artery echo
76821	Middle cerebral artery echo
76825	Echo exam of fetal heart
76826	Echo exam of fetal heart
76827	Echo exam of fetal heart
76828	Echo exam of fetal heart
76856	Us exam, pelvic, complete
76857	Us exam, pelvic, limited

ADDENDUM H.—LIST OF CPT [1]/ HCPCS CODES USED TO DESCRIBE CERTAIN DESIGNATED HEALTH SERVICE CATEGORIES [2] UNDER SECTION 1877 OF THE SOCIAL SECURITY ACT—Continued

[Effective Date: All codes are effective January 1, 2006, except those followed by an asterisk. Codes followed by an asterisk will become effective on January 1, 2007.]

76870	Us exam, scrotum
76880	Us exam, extremity
76885	Us exam infant hips, dynamic
76886	Us exam infant hips, static
76970	Ultrasound exam follow-up
76977	Us bone density measure
76999	Echo examination procedure
78000*	Thyroid, single uptake
78001*	Thyroid, multiple uptakes
78003*	Thyroid suppress/stimul
78006*	Thyroid imaging with uptake
78007*	Thyroid image, mult uptakes
78010*	Thyroid imaging
78011*	Thyroid imaging with flow
78015*	Thyroid met imaging
78016*	Thyroid met imaging/studies
78018*	Thyroid met imaging, body
78020*	Thyroid met uptake
78070*	Parathyroid nuclear imaging
78075*	Adrenal nuclear imaging
78099*	Endocrine nuclear procedure
78102*	Bone marrow imaging, ltd
78103*	Bone marrow imaging, mult
78104*	Bone marrow imaging, body
78110*	Plasma volume, single
78111*	Plasma volume, multiple
78120*	Red cell mass, single
78121*	Red cell mass, multiple
78122*	Blood volume
78130*	Red cell survival study
78135*	Red cell survival kinetics
78140*	Red cell sequestration
78185*	Spleen imaging
78190*	Platelet survival, kinetics
78191*	Platelet survival
78195*	Lymph system imaging
78199*	Blood/lymph nuclear exam
78201*	Liver imaging
78202*	Liver imaging with flow
78205*	Liver imaging (3D)
78206*	Liver image (3d) with flow
78215*	Liver and spleen imaging
78216*	Liver & spleen image/flow
78220*	Liver function study
78223*	Hepatobiliary imaging
78230*	Salivary gland imaging
78231*	Serial salivary imaging
78232*	Salivary gland function exam
78258*	Esophageal motility study
78261*	Gastric mucosa imaging
78262*	Gastroesophageal reflux exam
78264*	Gastric emptying study
78270*	Vit B-12 absorption exam
78271*	Vit B-12 absrp exam, int fac
78272*	Vit B-12 absorp, combined
78278*	Acute GI blood loss imaging
78282*	GI protein loss exam
78290*	Meckel's divert exam
78291*	Leveen/shunt patency exam
78299*	GI nuclear procedure
78300*	Bone imaging, limited area
78305*	Bone imaging, multiple areas
78306*	Bone imaging, whole body
78315*	Bone imaging, 3 phase
78320*	Bone imaging (3D)
78350	Bone mineral, single photon
78399*	Musculoskeletal nuclear exam
78414*	Non-imaging heart function
78428*	Cardiac shunt imaging
78445*	Vascular flow imaging
78456*	Acute venous thrombus image
78457*	Venous thrombosis imaging
78458*	Ven thrombosis images, bilat
78459*	Heart muscle imaging (PET)
78460*	Heart muscle blood, single
78461*	Heart muscle blood, multiple
78464*	Heart image (3d), single
78465*	Heart image (3d), multiple
78466*	Heart infarct image
78468*	Heart infarct image (ef)
78469*	Heart infarct image (3D)
78472*	Gated heart, planar, single
78473*	Gated heart, multiple
78478*	Heart wall motion add-on
78480*	Heart function add-on
78481*	Heart first pass, single
78483*	Heart first pass, multiple
78491*	Heart image (pet), single
78492*	Heart image (pet), multiple
78494*	Heart image, spect
78496*	Heart first pass add-on
78499*	Cardiovascular nuclear exam
78580*	Lung perfusion imaging
78584*	Lung V/Q image single breath
78585*	Lung V/Q imaging
78586*	Aerosol lung image, single
78587*	Aerosol lung image, multiple
78588*	Perfusion lung image
78591*	Vent image, 1 breath, 1 proj
78593*	Vent image, 1 proj, gas
78594*	Vent image, mult proj, gas
78596*	Lung differential function
78599*	Respiratory nuclear exam
78600*	Brain imaging, ltd static
78601*	Brain imaging, ltd w/flow
78605*	Brain imaging, complete
78606*	Brain imaging, compl w/flow
78607*	Brain imaging (3D)
78608*	Brain imaging (PET)
78609*	Brain imaging (PET)
78610*	Brain flow imaging only
78615*	Cerebral vascular flow image
78630*	Cerebrospinal fluid scan
78635*	CSF ventriculography
78645*	CSF shunt evaluation
78647*	Cerebrospinal fluid scan
78650*	CSF leakage imaging
78660*	Nuclear exam of tear flow
78699*	Nervous system nuclear exam
78700*	Kidney imaging, static
78701*	Kidney imaging with flow
78704*	Imaging renogram
78707*	Kidney flow/function image
78708*	Kidney flow/function image
78709*	Kidney flow/function image
78710*	Kidney imaging (3D)
78715*	Renal vascular flow exam
78725*	Kidney function study
78730*	Urinary bladder retention
78740*	Ureteral reflux study
78760*	Testicular imaging
78761*	Testicular imaging/flow
78799*	Genitourinary nuclear exam
78800*	Tumor imaging, limited area
78801*	Tumor imaging, mult areas
78802*	Tumor imaging, whole body
78803*	Tumor imaging (3D)
78804*	Tumor imaging, whole body
78805*	Abscess imaging, ltd area
78806*	Abscess imaging, whole body
78807*	Nuclear localization/abscess
78811*	Tumor imaging (pet), limited
78812*	Tumor image (pet)/skul-thigh
78813*	Tumor image (pet) full body
78814*	Tumor image pet/ct, limited
78815*	Tumor image pet/ct skul-thigh
78816*	Tumor image pet/ct full body
78890*	Nuclear medicine data proc
78891*	Nuclear med data proc
78999*	Nuclear diagnostic exam
91110	Gi tract capsule endoscopy
93303	Echo transthoracic
93304	Echo transthoracic
93307	Echo exam of heart
93308	Echo exam of heart
93320	Doppler echo exam, heart [if used in conjunction with 93303-93308]
93321	Doppler echo exam, heart [if used in conjunction with 93303-93308]
93325	Doppler color flow add-on [if used in conjunction with 93303-93308]
93875	Extracranial study
93880	Extracranial study
93882	Extracranial study
93886	Intracranial study
93888	Intracranial study
93890	Tcd, vasoreactivity study
93892	Tcd, emboli detect w/o inj
93922	Extremity study
93923	Extremity study
93924	Extremity study
93925	Lower extremity study
93926	Lower extremity study
93930	Upper extremity study
93931	Upper extremity study
93965	Extremity study
93970	Extremity study
93971	Extremity study
93975	Vascular study
93976	Vascular study
93978	Vascular study
93979	Vascular study
93980	Penile vascular study
93981	Penile vascular study
93990	Doppler flow testing
A4641*	Diagnostic imaging agent
A4642*	Satumomab pendetide per dose
A9500*	Technetium TC 99m sestamibi
A9502*	Technetium TC99M tetrofosmin
A9503*	Technetium TC 99m medronate
A9504*	Technetium tc 99m apcitide
A9505*	Thallous chloride TL 201/mci
A9507*	Indium/111 capromab pendetid
A9508*	Iobenguane sulfate I-131
A9510*	Technetium TC99m Disofenin
A9511*	Technetium TC 99m depreotide
A9512*	Technetiumtc99mpertechnetate
A9513*	Technetium tc-99m mebrofenin
A9514*	Technetiumtc99m pyrophosphate
A9515*	Technetium tc-99m pentetate
A9516*	I-123 sodium iodide capsule
A9519*	Technetiumtc-99mmacroag albu
A9520*	Technetiumtc-99m sulfur clld
A9521*	Technetiumtc-99m exametazine
A9522*	Indium111ibritumomabtiuxetan
A9524*	Iodinated I-131 serumalbumin
A9526*	Ammonia N-13, per dose
A9528*	Dx I131 so iodide cap millic
A9529*	Dx I131 so iodide sol millic
A9531*	Dx I131 so iodide microcurie

ADDENDUM H.—LIST OF CPT [1]/ HCPCS CODES USED TO DESCRIBE CERTAIN DESIGNATED HEALTH SERVICE CATEGORIES [2] UNDER SECTION 1877 OF THE SOCIAL SECURITY ACT—Continued

[Effective Date: All codes are effective January 1, 2006, except those followed by an asterisk. Codes followed by an asterisk will become effective on January 1, 2007.]

A9533*	I-131 tositumomab diagnostic
A9700*	Echocardiography contrast
G0130	Single energy x-ray study
G0202	Screeningmammographydigital
G0204	Diagnosticmammographydigital
G0206	Diagnosticmammographydigital
G0288	Recon, CTA for surg plan
Q0092	Set up port xray equipment
Q3000*	Rubidium RB-82
Q3002*	Gallium ga 67
Q3003*	Technetium tc99m bicisate
Q3004*	Xenon xe 133
Q3005*	Technetium tc99m mertiatide
Q3006*	Technetium tc99m glucepatate
Q3007*	Sodium phosphate p32
Q3008*	Indium 111-in pentetreotide
Q3009*	Technetium tc99m oxidronate
Q3010*	Technetium tc99mlabeledrbcs
Q3011*	Chromic phosphate p32
Q3012*	Cyanocobalamin cobalt co57
Q9945*	LOCM<=149mg/ml iodine, 1 ml
Q9946*	LOCM 150-199mg/ml iodine,1ml
Q9947*	LOCM 200-249mg/ml iodine,1ml
Q9948*	LOCM 250-299mg/ml/iodine,1ml
Q9949*	LOCM 300-349mg/ml iodine,1ml
Q9950*	LOCM 350-399mg/ml iodine,1ml
Q9951*	LOCM>=400 mg/ml iodine,1ml
Q9952*	Inj Gad-base MR contrast, ml
Q9953*	Inj Fe-base MR contrast, ml
Q9954*	Oral MR contrast, 100ml
Q9955*	Inj perflexane lip micros, ml
Q9956*	Inj octafluoropropane mic,ml
Q9957*	Inj perflutren lip micros, ml
R0070	Transport portable x-ray
R0075	Transport port x-ray multipl

RADIATION THERAPY SERVICES AND SUPPLIES

Include the following CPT and HCPCS codes:

0073T	Delivery, comp imrt
0082T	Stereotactic rad delivery
0083T	Stereotactic rad tx mngmt
19296	Place po breast cath for rad
19297	Place breast cath for rad
19298	Place breast rad tube/caths
31643	Diag bronchoscope/catheter
55859	Percut/needle insert, pros
57155	Insert uteri tandems/ovoids
58346	Insert heyman uteri capsule
61770	Incise skull for treatment
61793	Focus radiation beam
77261	Radiation therapy planning
77262	Radiation therapy planning
77263	Radiation therapy planning
77280	Set radiation therapy field
77285	Set radiation therapy field
77290	Set radiation therapy field
77295	Set radiation therapy field
77299	Radiation therapy planning
77300	Radiation therapy dose plan
77301	Radiotherapy dose plan, imrt
77305	Teletx isodose plan simple
77310	Teletx isodose plan intermed
77315	Teletx isodose plan complex
77321	Special teletx port plan
77326	Brachytx isodose calc simp
77327	Brachytx isodose calc interm
77328	Brachytx isodose plan compl
77331	Special radiation dosimetry
77332	Radiation treatment aid(s)
77333	Radiation treatment aid(s)
77334	Radiation treatment aid(s)
77336	Radiation physics consult
77370	Radiation physics consult
77399	External radiation dosimetry
77401	Radiation treatment delivery
77402	Radiation treatment delivery
77403	Radiation treatment delivery
77404	Radiation treatment delivery
77406	Radiation treatment delivery
77407	Radiation treatment delivery
77408	Radiation treatment delivery
77409	Radiation treatment delivery
77411	Radiation treatment delivery
77412	Radiation treatment delivery
77413	Radiation treatment delivery
77414	Radiation treatment delivery
77416	Radiation treatment delivery
77417	Radiology port film(s)
77418	Radiation tx delivery, imrt
77421	Stereoscopic x-ray guidance
77422	Neutron beam tx, single
77423	Neutron beam tx, complex
77427	Radiation tx management, x5
77431	Radiation therapy management
77432	Stereotactic radiation trmt
77470	Special radiation treatment
77499	Radiation therapy management
77520	Proton trmt, simple w/o comp
77522	Proton trmt, simple w/comp
77523	Proton trmt, intermediate
77525	Proton treatment, complex
77600	Hyperthermia treatment
77605	Hyperthermia treatment
77610	Hyperthermia treatment
77615	Hyperthermia treatment
77620	Hyperthermia treatment
77750	Infuse radioactive materials
77761	Apply intrcav radiat simple
77762	Apply intrcav radiat interm
77763	Apply intrcav radiat compl
77776	Apply interstit radiat simpl
77777	Apply interstit radiat inter
77778	Apply interstit radiat compl
77781	High intensity brachytherapy
77782	High intensity brachytherapy
77783	High intensity brachytherapy
77784	High intensity brachytherapy
77789	Apply surface radiation
77790	Radiation handling
77799	Radium/radioisotope therapy
79005*	Nuclear rx, oral admin
79101*	Nuclear rx, iv admin
79200*	Nuclear rx, intracav admin
79300*	Nuclr rx, interstit colloid
79403*	Hematopoietic nuclear tx
79440*	Nuclear rx, intra-articular
79445*	Nuclear rx, intra-arterial
79999*	Nuclear medicine therapy
92974	Cath place, cardio brachytx
A9517*	Th I131 so iodide cap millic
A9523*	Yttrium90ibritumomabtiuxetan
A9530*	Th I131 so iodide sol millic
A9532*	I-125 serum albumin micro
A9534*	I-131 tositumomab therapeut
A9600*	Strontium-89 chloride
A9605*	Samarium sm153 lexidronamm
A9699*	Noc therapeutic radiopharm
G0173	Stereo radiosurgery,complete
G0243	Multisour photon stero treat
G0251	Linear acc based stero radio
G0339	Robot lin-radsurg com, first
G0340	Robt lin-radsurg fractx 2-5
Q3001*	Brachytherapy radioelements
Q3007*	Sodium phosphate p32
Q3011*	Chromic phosphate p32

EPO AND OTHER DIALYSIS-RELATED DRUGS

The physician self-referral prohibition does not apply to the following codes for EPO and other dialysis-related drugs furnished in or by an ESRD facility if the conditions in § 411.355(g) are satisfied:

J0630	Calcitonin salmon injection
J0636	Inj calcitriol per 0.1 mcg
J0882	Darbepoetin alfa, esrd use
J0886	Epoetin alfa, esrd
J0895	Deferoxamine mesylate inj
J1270	Injection, doxercalciferol
J1751	Iron dextran 165 injection
J1752	Iron dextran 267 injection
J1756	Iron sucrose injection
J1955	Inj levocarnitine per 1 gm
J2501	Paricalcitol
J2916	Na ferric gluconate complex
J2993	Reteplase injection
J2995	Inj streptokinase /250000 IU
J2997	Alteplase recombinant
J3364	Urokinase 5000 IU injection
P9041	Albumin (human),5%, 50ml
P9045	Albumin (human), 5%, 250ml
P9046	Albumin (human), 25%, 20ml
P9047	Albumin (human), 25%, 50ml

PREVENTIVE SCREENING TESTS, IMMUNIZATIONS AND VACCINES

The physician self-referral prohibition does not apply to the following tests if they are performed for screening purposes and satisfy the conditions in § 411.355(h):

76083	Computer mammogram add-on
76092	Mammogram, screening
80061	Lipid panel [only when billed with one of the following ICD-9-CM codes: V81.0, V81.1, or V.81.2]
82465	Assay, bld/serum cholesterol [only when billed with one of the following ICD-9-CM codes: V81.0, V81.1, or V.81.2]
82947	Assay, glucose, blood quant [only when billed with ICD-9-CM code V77.1]
82950	Glucose test [only when billed with ICD-9-CM code V77.1]
82951	Glucose tolerance test (GTT) [only when billed with ICD-9-CM code V77.1]
83718	Assay of lipoprotein [only when billed with one of the following ICD-9-CM codes: V81.0, V81.1, or V.81.2]
84478	Assay of triglycerides [only when billed with one of the following ICD-9-CM codes: V81.0, V81.1, or V.81.2]
G0103	Psa, total screening
G0107	CA screen; fecal blood test
G0123	Screen cerv/vag thin layer
G0124	Screen c/v thin layer by MD
G0141	Scr c/v cyto,autosys and md
G0143	Scr c/v cyto,thinlayer,rescr
G0144	Scr c/v cyto,thinlayer,rescr
G0145	Scr c/v cyto,thinlayer,rescr

ADDENDUM H.—LIST OF CPT [1]/ HCPCS CODES USED TO DESCRIBE CERTAIN DESIGNATED HEALTH SERVICE CATEGORIES [2] UNDER SECTION 1877 OF THE SOCIAL SECURITY ACT—Continued

[Effective Date: All codes are effective January 1, 2006, except those followed by an asterisk. Codes followed by an asterisk will become effective on January 1, 2007.]

G0147	Scr c/v cyto, automated sys
G0148	Scr c/v cyto, autosys, rescr
G0202	Screening mammographydigital
G0328	Fecal blood scrn immunoassay
P3000	Screen pap by tech w md supv
P3001	Screening pap smear by phys
The physician self-referral prohibition does not apply to the following immunization and vaccine codes if they satisfy the conditions in § 411.355(h):	
90655	Flu vaccine no preserv 6-35m
90656	Flu vaccine no preserv 3 & >
90657	Flu vaccine, 6-35 mo, im
90658	Flu vaccine age 3 & over, im
90732	Pneumococcal vaccine
90740	Hepb vacc, ill pat 3 dose im
90743	Hep b vacc, adol, 2 dose, im
90744	Hepb vacc ped/adol 3 dose im
90746	Hep b vaccine, adult, im
90747	Hepb vacc, ill pat 4 dose im

[1] CPT codes and descriptions only are copyright 2005 American Medical Association. All rights are reserved and applicable FARS/DFARS clauses apply.

[2] This list does not include codes for the following designated health service (DHS) categories: durable medical equipment and supplies; parenteral and enteral nutrients, equipment and supplies; prosthetics, orthotics, and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services. For the definitions of these DHS categories, refer to 42 CFR 411.351. For more information, refer to http://cms.hhs.gov/medlearn/refphys.asp.

* Nuclear medicine services and supplies assigned an asterisk will be subject to the physician self-referral prohibition effective January 1, 2007.

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